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ABSTRACT

The Healthy Start Initiative is a national 5-year demonstration program that uses a broad range of community-driven, system development approaches to reduce infant mortality and improve the health and well-being of women, infants, children, and families. This volume, fifth in the series, deals with the topic of collaborating with managed care organizations. The book is designed to assist Healthy Start projects and their subcontracting service providers in developing proposals and entering into contracts with health maintenance organizations (HMOs) that serve Medicaid clients. It is designed to help these organizations: (1) understand and evaluate the needs and responsibilities of HMOs; (2) evaluate the capabilities of the Healthy Start project and its subcontractors; (3) identify the specific needs of targeted HMOs, and evaluate and adapt the organizational structure and services of the Healthy Start project and its service providers to meet those needs; (4) develop and market a managed care proposal; and (5) propose and negotiate a managed care contract. This report has 11 chapters: (1) "Introduction"; (2) "HMOs: The Basics"; (3) "Your State's Medical Managed Care Program and Opportunities for Healthy Start"; (4) "Factors Influencing an HMO's Willingness to Contract with a Healthy Start Project"; (5) "Becoming an Attractive Partner to HMOs"; (6) "Preparing To Act as a Contractor to HMOs"; (7) "Strategic Planning: How To Decide What Services To Offer to HMOs"; (8) "Developing and Marketing a Managed Care Proposal"; (9) "Proposing and Negotiating a Contract"; (10) "Ongoing Issues";

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and (11) "Conclusion." Five appendices contain a glossary of terms, annotated HMO-Healthy Start Project contracts, a Healthy Start Project subcontractor agreement, a list of state Medicaid directors, and state maternal and child health contacts. (LPP)

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THE HEALTHY START INITIATIVE

A COMMUNITY-DRIVEN APPROACH TO INFANT MORTALITY REDUCTION

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Collaboration with Managed Care Organizations

Volume V

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A COMMUNITY-DRIVEN
APPROACH TO INFANT
MORTALITY REDUCTION

Volume V

Collaboration with Managed Care Organizations

A COMMUNITY DRIVEN
APPROACH TO INFANT
MORTALITY REDUCTION

Volume V

Collaboration with Managed Care Organizations

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The Healthy Start Initiative is a program funded under Section 301 of the Public Health Service Act to identify and implement a broad range of community-driven strategies and interventions that could successfully and significantly reduce infant mortality. In its demonstration phase, 1991–97, this Initiative supports 22 urban and rural communities to implement such strategies and interventions. Additional communities will be funded as the Initiative begins its replication phase in late 1997.

The mission of the National Center for Education in Maternal and Child Health is to promote and improve the health, education, and well-being of children and families by leading a national effort to collect, develop, and disseminate information and educational materials on maternal and child health; and by collaborating with public agencies, voluntary and professional organizations, research and training programs, policy centers, and others to advance knowledge in programs, service delivery, and policy development. Established in 1982 at Georgetown University, NCEMCH is part of the Georgetown Public Policy Institute. NCEMCH is funded primarily by the U.S. Department of Health and Human Services through its Maternal and Child Health Bureau.

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Acknowledgments

We wish to thank all those who contributed to this volume. Most importantly, we wish to thank the 22 Healthy Start sites funded during the Healthy Start Initiative's demonstration phase. They have grappled for the past six years to ensure that changing health care systems improve their services to women, children, and families. This volume grows out of their struggles and their need to continue to build bridges with all sectors of the health care system. We hope this volume helps to build those bridges.

Foreword

This volume grows out of a recognition that as health care systems change, community-based programs must change with them. The basis for this volume has been the technical assistance provided to the 22 Healthy Start sites as they work to build relationships and sustainability. We know that the Healthy Start sites, and indeed all community-based programs, are working in ever-changing systems, no two of which are the same.

The Healthy Start Initiative was first developed as a national demonstration program that uses a community-driven, systems development approach to reduce infant mortality and improve the health and well-being of women, infants, children, and families. During its upcoming replication phase, Healthy Start hopes to fulfill its commitment to disseminating its lessons to those who can put them into practice.

In keeping with the spirit of spreading the Healthy Start lessons, this book is intended for three audiences:

- Healthy Start sites and those involved with the Healthy Start Initiative
- Community-based initiatives that are faced with the challenge of building relationships to managed care

CHICAGO HEALTHY START

- Community-based initiatives that seek to learn the lessons of Healthy Start, perhaps replicating its philosophy and methods

Because of the widespread interest in learning about Healthy Start, the projects' acomplishments, and the lessons learned in filling the service gaps in their communities, this publication is part of the multivolume series *The Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction*. The series provides a mechanism by which current and critical information about the projects' activities can be shared and widely disseminated. Other volumes in the series include:

- *Volume I: Consortia Development* (Spring 1994)
- *Volume II: Early Implementation—Lessons Learned* (Fall 1994)
- *Volume III: Sustainability* (Fall 1995)
- *Volume IV: Community Outreach* (Fall 1996)
- *Volume VI: Healthy Start Replication Manual* (planned)
- *Volume VII: Public Information and Education Campaigns* (planned)
- *Volume VIII: Telling the Healthy Start Stories* (planned)

The practical information presented here can give programs a head start in their efforts to build bridges to managed care systems in their communities. We hope this volume contributes to a spirit of collaboration, and therefore to sustaining crucial programs around the nation.

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BALTIMORE HEALTHY START

1

INTRODUCTION

This manual will assist Healthy Start projects and their subcontracting service providers in developing proposals and entering into contracts with health maintenance organizations (HMOs) that serve Medicaid clients. This document will assist these organizations to:

- Understand and evaluate the needs and responsibilities of HMOs
- Evaluate the capabilities of the Healthy Start project and its subcontractors
- Identify the specific needs of targeted HMOs, and evaluate and adapt the organizational structure and services of the Healthy Start project and its service providers to meet those needs
- Develop and market a managed care proposal
- Propose and negotiate a managed care contract

While this manual was developed with the needs of Healthy Start projects in mind, the principles and actions described are appropriate for any community-based organization.

To assist the reader in understanding these issues, a hypothetical Healthy Start project called "Metropolis Healthy Start" will be used to identify issues and bases for decisions. The project director of Metropolis Healthy Start is Penny Leight. Metropolis has one HMO ("Old Medicaid HMO") that currently provides services to Medicaid clients. Enrollment in Old Medicaid HMO is voluntary. A relatively small number of the Medicaid clients who are mothers and children have enrolled in Old Medicaid HMO. The state Medicaid agency has recently decided to require all Aid to Families with Dependent Children (AFDC) clients to enroll in Medicaid HMOs. Three HMOs are interested in participating in this program. In addition to Old Medicaid HMO, an inner-city hospital has recently formed an HMO ("New Medicaid HMO") and will submit a proposal. A well-established HMO ("Commercial HMO") serving the commercial population of Metropolis has also decided to develop a Medicaid program and pursue a contract. Penny Leight believes that all three HMOs—Old Medicaid HMO, New Medicaid HMO, and Commercial HMO—are potential purchasers of Metropolis Healthy Start services.

This manual provides suggestions and a range of approaches to guide Healthy Start projects and other community-based projects through the process of developing relationships with HMOs. Project representatives should use their judgment and experience in determining how to proceed. Although contracting opportunities are discussed from the perspective of the Healthy Start project, the guidance also applies to Healthy Start subcontractors pursuing contracts directly with an HMO.

We are aware that many of the Healthy Start projects are located in areas that have not yet implemented Medicaid managed care programs. However, Healthy Start projects may be able to contract with HMOs to provide services to their commercial populations. In many areas, the commercial population resembles the Medicaid population with regard to demographics, health status, and risk factors. HMOs located in such areas are interested in providers with experience with an at-risk population. In addition, HMOs are interested in Healthy Start programs that will increase compliance with well-baby care and immunizations for their commercial enrollment. In areas without operating Medicaid managed care programs, providing services to an HMO's commercial population may offer Healthy Start projects a mechanism for establishing relationships that can be capitalized on when a Medicaid program is implemented.

We also recognize that states are in different stages of implementation and development of Medicaid managed care programs. In response to increasing budget pressures, states are turning to managed care to provide services to their Medicaid populations. States without Medicaid managed care programs are developing them, and states that have programs are refining them. As a result, we address the range of opportunities for Healthy Start programs to participate in Medicaid managed care—from providing input to states regarding development of such programs to working with mature Medicaid HMOs in areas with established programs.

Finally, the manual includes information to guide community-based organizations in entering into a range of relationships with HMOs. Each Healthy Start project will need to determine the scope of the relationship it is prepared to enter with HMOs. Some projects may want less formal relationships, or agreements on a smaller scale. In addition, HMOs may want to start with a small-scale pilot or demonstration relationship that is less formal in nature, to allow the HMO to evaluate the value of the service. As a result, Healthy Start projects may not need to engage in all the activities outlined in this manual.

To assist the reader, this manual contains appendices that include:

- A glossary of managed care terms
- A lengthy model contract between an HMO and a Healthy Start project
- A brief model contract between an HMO and a Healthy Start project
- A model contract between a Healthy Start project and a subcontracting service provider
- A list of state Medicaid agencies with telephone numbers and contacts
- A list of each maternal and child health state agency with telephone numbers and contacts

Beginning to Pursue Managed Care Relationships

Most states are launching or expanding Medicaid managed care programs that require pregnant women and children eligible for Medicaid to enroll in HMOs. Timing is everything. Healthy Start projects and/or their subcontracting service providers need to begin by taking several immediate actions:

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- Develop a mission statement for your managed care products and begin evaluating the Healthy Start project's administrative structure to determine whether changes need to be made to become an attractive and effective HMO partner
- Identify a Healthy Start project representative to be the principal manager of the initiative to contract with HMOs
- Inform state Medicaid agencies of your interest in serving the HMO's Medicaid clients and in being involved in program development
- Inform HMOs of your interest in developing cooperative relationships

Most of the Healthy Start project's time and energy is spent providing or overseeing services and meeting grant requirements. All of these immediate obligations can detract from long-term objectives, such as establishing HMO relationships. Identifying a single representative to take the lead on managed care issues will help the Healthy Start project focus on contracting with HMOs. The managed care representative needs to have the responsibility, resources, and training to take the lead in proposing and negotiating contracts with HMOs. Preparation for HMO contracting involves being ready not only to provide services but also to perform all of the reporting, record keeping, and other administrative tasks required by the HMO and the state Medicaid agency. Immediate attention to these issues is important.

Regardless of whether the project is ready to begin discussions about formal relationships or whether the state has implemented a Medicaid managed care program, the project should develop relationships with HMOs. The Healthy Start project should look for ways that it can work with HMOs. For example, the project could:

- Invite HMOs to participate in the Healthy Start project's program
- Make an appointment to discuss Healthy Start programs or accomplishments and leave copies of fact sheets, brochures, or reports
- Discuss findings made regarding the success of its programs

It is easier for a community-based organization such as Healthy Start to cultivate a relationship with an HMO before pursuing a contract than to have the initial contact occur during a meeting when the organization is submitting a proposal.

In addition, the organization needs to cultivate a good relationship with the state Medicaid agency, particularly with the managed care staff. The agency staff can advocate for the Healthy Start project when the agency is developing new programs or making policy decisions in which the project may have an interest. (Further discussion on working with state Medicaid agencies can be found in Chapter 3.)

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2

HMOs: THE BASICS

What Is an HMO?

An HMO has three key characteristics:

1. It offers comprehensive health care services to an enrolled population.
2. It contracts with an established panel of providers to deliver services to its enrolled population.
3. It is prepaid to provide these services.

In almost every state, organizations that perform these functions are required to be licensed under the state's HMO law. The federal Medicaid law [Section 1903(m) of the Social Security Act] also has its own definition of HMO. Any organization that contracts with a state Medicaid agency to be "at risk" (to receive a fixed prepayment regardless of utilization) for a comprehensive range of Medicaid services is considered an HMO. The federal Medicaid law has special requirements applicable to HMOs. Those requirements are enforced by an agency designated by the state, hereafter referred to as the state Medicaid agency.

While most states call their managed care contractors HMOs, some states use more general labels such as managed care organizations or health care partnerships. For simplicity, this document will use the term HMO to describe these organizations. The world of managed care is filled with other imprecise and ambiguous terms, such as integrated delivery system, provider-sponsored network, and physician-hospital organization. These terms do not have uniform meanings, but generally refer to organizations, usually sponsored by providers, that contract with HMOs to provide services to HMO members.

Types of HMOs

HMOs are divided into model types based on how physician services are provided. The strategies a Healthy Start project may employ in contracting with an HMO vary significantly depending on the type of HMO. The American Association of Health Plans, the HMO trade association, identifies these four HMO models:

> *Group:* An organized prepaid health care system that contracts with one independent group practice to provide health services.
>
> *Independent Practice Association (IPA):* An organized prepaid health care system that contracts directly with physicians in independent practice, with one or more associations of physicians in independent practice, and/or with one or more multispecialty group practices (but is predominantly organized around solo/single-specialty practices) to provide health services.
>
> *Network:* An organized prepaid health care system that contracts with two or more independent group practices to provide health services.
>
> *Staff:* An organized prepaid health care system that delivers health services though a salaried physician group that is employed by the HMO.

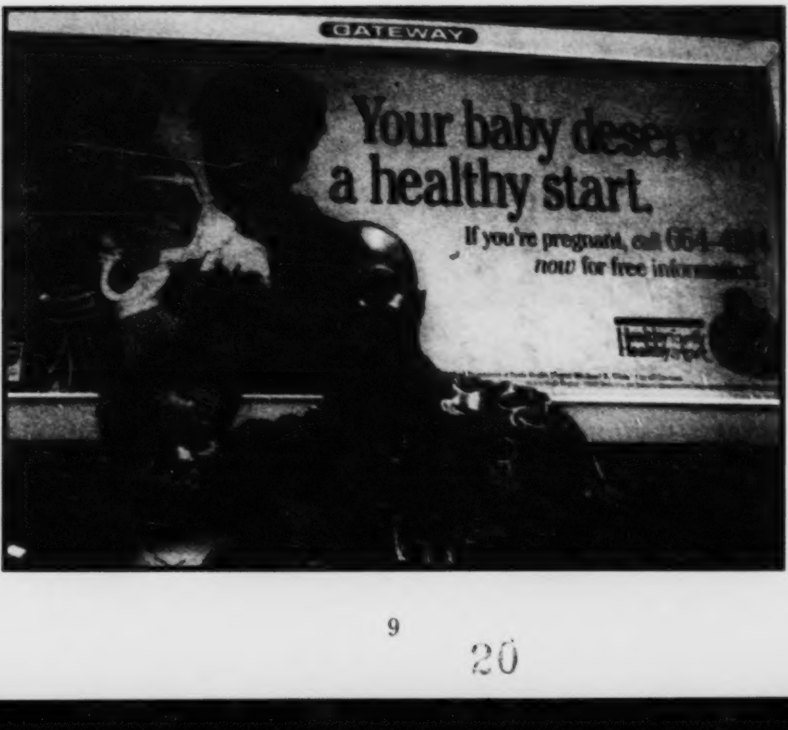
Penny Leight has assigned Lark Kent the responsibility to develop HMO proposals. After some informal discussions with HMO representatives, Lark realizes that Commercial HMO is a staff model and is accustomed to having its own employees perform all of its functions. It may be difficult to persuade Commercial HMO to contract out the functions that Metropolis Healthy Start wants to perform. Lark also finds out that New Medicaid HMO will be a network model HMO. Large medical groups will be providing many of the physician services. These large medical groups will also be delegated many of the administrative responsibilities. Some of these large medical groups have been involved on Metropolis Healthy Start's consortium. Lark realizes that Metropolis Healthy Start may need to negotiate and contract with the large medical groups rather than New Medicaid HMO.

HMO Providers

Some HMOs have an agreement with only one organization to provide or arrange for all the health services on behalf of the HMO. Other HMOs may have more than 1,000 contracts with different individual providers. "Provider" is a general term that refers to any organization or person that furnishes health services or goods to an HMO member.

Providers are divided into different categories or groupings. One division is between institutional providers (e.g., hospitals, nursing homes, ambulatory surgical facilities) and noninstitutional providers, including physicians. Noninstitutional services are frequently called professional services, which may be divided between physician and nonphysician services. HMOs also provide ancillary services, such as laboratory work or x-rays, which typically accompany physician or other provider services.

In many cases, the services that a Healthy Start project provides are viewed by the HMO as enabling or social, rather than health, services. In some instances, Healthy Start projects will want to partner with health care providers, such as community health centers or other federally qualified health centers, to offer the HMO an integrated package of enabling and health services that the Healthy Start project may have already established during its federal funding stage.



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Provider Payment Arrangements and Delegation of Financial Risk

Acceptance and delegation of financial risk are integral concepts for HMOs. Financial risk is the uncertainty of loss or expense levels due to the inability to predict with complete certainty the exact health care needs of the HMO's enrollees. In addition to accepting financial risk in the form of a premium payment, most HMOs transfer some risk to network providers. HMOs use a variety of different provider payment arrangements that vary by the amount of financial risk transferred to providers. The organization that assumes the financial risk for the costs associated with clinically high-risk mothers and low birthweight babies is more likely to purchase Healthy Start project interventions to try to reduce those costs. The HMO may not benefit from cost savings as a result of a strong case management and outreach program if it has already transferred financial risk for providing maternity and newborn services to a large physician group. The Healthy Start project needs to consider this when it tailors its marketing strategy to the HMO. In such a case, the Healthy Start project may want to market services to the physician group.

The following are examples of how HMOs pay physicians:

Capitation: In most cases, primary care physicians are paid on a capitated basis—a fixed monthly payment per member that does not vary based on service utilization. However, in areas where managed care is relatively new and physicians are unaccustomed to accepting risk, HMOs are likely to use another payment mechanism.

Fee-for-service: Under this payment arrangement, physicians are paid a fee, generally according to a schedule, for each service they provide. Specialty physicians are frequently paid based on a fee schedule, although some specialists may receive a capitation payment.

Fee-for-service with a withhold: Under this mechanism, a percentage of the fee-for-service payments are withheld and refunded based on performance, utilization, quality, and/or other measures.

Salary: Physicians paid on a salaried basis are employees who receive a fixed compensation paid regularly for services. The physician does not assume financial risk based on the cost or amount of services provided. In some cases, the physician's salary may be supplemented by a bonus based on performance on consumer satisfaction, utilization, or quality measures or on the financial performance of the HMO.

Payment per episode of care: Obstetricians are frequently paid on this basis with a fixed amount to cover all services during the pregnancy.

A group of physicians may be paid a capitation payment for all the services its physicians provide as well as some referral services. As the size of the physician group increases, its ability to assume greater portions of risk also increases. Large physician groups may also have the delegated responsibility to perform some of the administrative functions of the HMO, such as utilization management. Healthy Start projects need to be aware of whether the HMO has delegated some of its responsibilities. If so, this delegation may bear on the nature of the Healthy Start project's offered services and the entity to which the services will be offered.

Because operating a Medicaid HMO demands expertise that many commercial HMOs do not have, some commercial HMOs contract with Medicaid HMOs to assume all the risk and provide all the services to the HMO's Medicaid population. In such a case, the Healthy Start project would need to market itself to the subcontracting Medicaid HMO rather than the commercial HMO. These subcontracting organizations may be joint ventures between hospitals and physicians, or independent organizations financed by independent investors.

HMOs also pay for hospital services using a number of methods. In some cases, HMOs pay based on a fee schedule that may be a discount from the hospital's normal billed charges. In many cases, payments may be made on a per diem basis, with the hospital paid a fixed cost per day depending on the type of patient. Some arrangements provide for payment based on the diagnosis. There is a growing trend toward hospitals assuming more risk (e.g., receiving a capitation payment or a percentage of the HMO's premiums in return for assuming the risk for hospital services).

HMOs use a number of mechanisms to delegate risk to their providers. However, risk delegation often depends on whether providers in the HMO's service area have experience with managing financial risk and are willing to accept such risk. Risk delegation is less common in markets where managed care is a new concept. In determining how and to whom the Healthy Start project should market its services, the project must understand payment arrangements and know the types of arrangements used by a particular HMO.

3

YOUR STATE'S MEDICAID MANAGED CARE PROGRAM AND OPPORTUNITIES FOR HEALTHY START

Regardless of the state's stage of development and implementation of its Medicaid managed care programs, Healthy Start projects are well advised to contact the staff of the state agency administering the program. The Healthy Start project should ensure that the state staff has an understanding of Healthy Start's activities and an interest in the Medicaid managed care program. In addition, contact with the Medicaid state agency can help Healthy Start projects meet three objectives:

1. Determine the time schedule for development, piloting, and/or implementation, and the geographic area of the Medicaid managed care program if the state does not currently have an operating program
2. Influence the development and/or operation of the Medicaid managed care program
3. Learn about Medicaid managed care requirements that will influence the manner in which the Healthy Start project develops and markets its proposal to HMOs

Timing

The Healthy Start project needs to determine at what point the HMOs will be most receptive to a proposal. As local HMOs begin to develop networks to serve Medicaid enrollees, Healthy Start projects may be able to capitalize on their experiences with the Medicaid population. This is also the case when an HMO is new to the Medicaid market. Healthy Start projects can find out from the state Medicaid agency which HMOs have Medicaid contracts, the size of the HMO's Medicaid enrollment (if the HMO has already begun enrollment), and how long the HMO has had the contract.

In addition, Healthy Start projects may also be able to take advantage of markets where Medicaid managed care is changing from voluntary to mandatory enrollment. In such an environment, HMOs can expect a substantial increase in enrollment and will need to expand their networks to accommodate a larger Medicaid enrollment. In addition, HMOs will be looking for contracting partners who will make their plans more attractive and competitive as beneficiaries choose an HMO.

Because the Metropolis HMOs are developing Medicaid managed care programs to correspond to the requirements of the Medicaid state agency, Metropolis Healthy Start wants to be prepared to offer its services to all three HMOs at the time the HMOs are willing and able to consider these proposals. Lark Kent has concluded that there is a good chance that all three HMOs will be receptive to considering a Metropolis Healthy Start proposal if the Medicaid state agency requires linkages with community and public health organizations. On the other hand, Lark believes that if an HMO is busy responding to a request for proposal that includes no mention of Healthy Start-type services or contracting with Healthy Start-type organizations, the HMO may be too busy at this time to consider a proposal by a Healthy Start project.

Influencing State Medicaid Managed Care Policy

Because the HMO's receptivity depends in part on the Medicaid managed care program's requirements in the state, the Healthy Start project should determine whether it is in a position to influence those requirements and what assistance it can obtain from other organizations in that effort. Any efforts to influence Medicaid managed care policy should be made in cooperation with related public and private organizations, including the state maternal and child health agency (of particular importance) and the state HMO association.

Most state Medicaid programs actively seek or allow the participation of community-based organizations in the design and implementation of the program. The design phase of the managed care program is the ideal time for a Healthy Start project to influence the standards adopted for the services that the Healthy Start project believes all HMO Medicaid clients should receive.

The Healthy Start project may influence the development of the Medicaid managed care program as the state develops a federal waiver request, as the state Medicaid agency develops programs or policy, and/or as regulatory proposals are made regarding ongoing oversight of the Medicaid managed care program.

Efforts to influence the development of the Medicaid managed care program could be intended to accomplish several objectives:

- The most direct objective would be to persuade the state Medicaid agency to require HMOs to contract with the Healthy Start project and/or its service providers.
- Another option is for the state Medicaid agency to require that HMOs contract with organizations that provide Healthy Start-type services.
- A third objective would be to ask the state Medicaid agency to require that HMOs provide Healthy Start-type services.
- A final objective is to have the state Medicaid agency encourage contracting with Healthy Start projects through selection criteria that favor contracting with public health or community-based organizations, or HMOs providing Healthy Start-type services.

States can establish Medicaid managed care programs by passing legislation or by making regulatory changes. However, for a state to establish a program under which beneficiaries are required to enroll in HMOs, the Health Care Financing Administration (HCFA) must approve a waiver request under Section 1115 or Section 1915(b) of the Social Security Act. States are required to obtain public input to submit a Section 1115 waiver request and frequently allow input in the development of Section 1915(b) waivers. The Healthy Start project could make efforts to encourage the state Medicaid agency to include Healthy Start-type services in the proposal to HCFA or a defined role for the Healthy Start project or affiliated organizations in the HMO's program. Following approval of a HCFA waiver, a Healthy Start project could have input at several other stages:

- In development of the state Medicaid agency's plans to implement the Medicaid managed care program
- In proposing terms in the contract between the state Medicaid agency and HMOs
- In development and implementation by the state Medicaid agency of work plans used to evaluate whether HMOs are meeting their requirements

Regardless of whether the state needs a Medicaid waiver, the Healthy Start project should explore opportunities to have input in the development of the Medicaid managed care program or in its implementation. The Healthy Start project can assist in the development of the quality assurance program or in any outreach requirements. The Healthy Start project may also suggest that the state Medicaid agency establish work groups to advise the agency on issues. Participation in a work group could allow the Healthy Start project to have an ongoing advisory role.

Learning About the State Medicaid Managed Care Program

Even if the Healthy Start project is not able to influence the design of the Medicaid managed care program, contact with the state Medicaid agency can provide the project with a great deal of information for use in developing its HMO strategy. Questions to ask include:

- If the state Medicaid agency does not already have a Medicaid managed care program in the Healthy Start project's area, what is its schedule for implementing a program?

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- What criteria does (or will) the state Medicaid agency use to select contractors? The criteria may influence how the Healthy Start project develops its proposal to the HMOs.
- How many contracts has (or will) the state Medicaid agency entered (enter) into in the Healthy Start project's service area? Which HMOs have applied for or been awarded contracts? If contracts have not yet been awarded, the Healthy Start project will want to target its efforts to expected winners.
- Who are (or will be) the Medicaid-eligible populations participating in the program?
- Are the HMOs (or will the HMOs be) required to cover the disabled population as well as the Aid to Families with Dependent Children (AFDC) eligibility group?* If so, the Healthy Start project may want to propose Healthy Start-type services to this population.
- Is the program (or will the program be) mandatory or voluntary? If the program is mandatory, the state Medicaid agency may limit the ability of HMOs to market their programs. If so, the HMOs might find linkages with community-based programs more desirable because they offer indirect marketing opportunities.

In addition, contacts with the state Medicaid agency could also give the Healthy Start project a better understanding of the administrative and substantive requirements that the Healthy Start project could have as a subcontractor to the HMO.

Opportunities

The structure of the state Medicaid managed care program may offer opportunities for Healthy Start projects. Some states pay for Healthy Start-type services, such as social case management services, separately rather than as a part of the HMO's capitation. The Healthy Start project may have opportunities in these states either to be paid for these services directly by the state or to be paid by the HMO when it receives payment for these services directly from the state Medicaid agency. The Healthy Start project should explore the possibilities.

In addition, the Healthy Start project should also investigate whether the state Medicaid agency funds other services outside of the HMO capitation payment. For example, the state Medicaid agency may be separately funding case management or outreach/tracking services for tuberculosis, sexually transmitted diseases, or AIDS. The Healthy Start project or its subcontracting service providers should consider expanding their scope of activities to encompass services provided to populations other than mothers and infants. However, the Healthy Start projects may need to use funds other than Healthy Start funds to develop such a program.

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* The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 replaced the AFDC program with the Temporary Assistance for Needy Families (TANF) program. The TANF program is a block grant under which states are free to establish the eligibility criteria.

4

FACTORS INFLUENCING AN HMO'S WILLINGNESS TO CONTRACT WITH A HEALTHY START PROJECT

Understanding the HMO's Perspective

Prior to developing a proposal for an HMO, the Healthy Start project should have an understanding of the factors that influence how the HMO will react to the proposal. An HMO's reactions are affected by a variety of economic and noneconomic business factors as well as the HMO's perception of its social responsibilities to its community. While HMOs are influenced by many of the same factors, not all HMOs will react the same way. An HMO's response to a Healthy Start proposal will vary by HMO in the same city as well as by staff person within the same HMO. Healthy Start projects need to be cautious about forming preconceived judgments before conducting the necessary preliminary inquiries discussed below.

Lark Kent may find that Old Medicaid HMO is satisfied with its existing program and believes that the services of Metropolis Healthy Start may be duplicative or unnecessary. On the other hand, Old Medicaid HMO may be familiar with Metropolis Healthy Start's services and reputation and excited about the possibility of working with Metropolis

Healthy Start. Commercial HMO may perceive a relationship with Metropolis Healthy Start as an excellent opportunity to enhance its own reputation in the community where the Medicaid clients live. However, Lark Kent will not know its reactions until she meets with Commercial HMO. In addition, such a meeting may also provide other leads of value to Lark.

Healthy Start projects currently offer services to all eligible residents living in their target areas. Healthy Start projects need to narrow their focus and orientation when developing proposals to provide services to the HMO's members. The HMO is compensated to provide services to its enrolled population, not the community at large.

On average, an HMO's Medicaid members will remain enrolled in the HMO for less than a year before the member disenrolls or loses Medicaid eligibility. Many women lose Medicaid eligibility in the postpartum period. Also, many state Medicaid agencies redetermine eligibility monthly, at which point many persons are found no longer eligible. This rapid turnover in membership means that HMOs will favor interventions that have short-term gains rather than interventions that may result in cost savings over several years—HMOs may favor programs that improve birth outcomes but may be less interested in programs that improve child development.

Economic Factors Influencing HMO Decisions

An HMO receives a fixed payment or capitation amount per enrollee from the state Medicaid agency. The economic viability of the program depends on the HMO ensuring that its costs do not exceed those revenues. In recent years, state legislatures and state Medicaid agencies have reduced or substantially limited the rate of increase of the payment rates to HMOs. HMOs are influenced by these efforts and may have an initial reluctance to spend money on programs that are not required under their state Medicaid contracts.

Because of the economic pressure placed on HMOs, Healthy Start projects need to be constantly aware that the HMOs are sensitive to costs. Consequently, the Healthy Start project must be prepared to successfully argue that its interventions will result in cost savings for the HMOs.

Lark Kent has been learning about HMOs and has discovered that the importance of an HMO's Medicaid revenues depends on whether it is predominantly a Medicaid or a Commercial HMO. Old Medicaid HMO, which is very dependent on Medicaid revenues, may be reluctant to contract with Metropolis Healthy Start if the Medicaid rates are low, unless the project Healthy Start can persuade Old Medicaid HMO that interventions will result in tangible cost savings. Lark thinks that Commercial HMO, which is large and has financially successful commercial products, may be more willing to work with Metropolis Healthy Start if the HMO has surpluses from its commercial operations that can initially subsidize shortfalls from its Medicaid operations.

Administrative Simplicity

An HMO operates an administratively complex system with hundreds or thousands of contracts for the provision of health and administrative services. It is expensive for an HMO to establish and maintain these arrangements, and

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HMOs are constantly looking for ways to operate more efficiently. As a result, Healthy Start projects should review the organization of responsibilities within their particular structure when preparing to contract with HMOs.

The services offered by Healthy Start projects are not easy for HMOs to develop or to operate because they demand experience with, and sensitivity to, the problems and concerns of the Medicaid population. Some HMOs may not be willing to develop and oversee intensive social case management and outreach programs. In addition, if the services the HMO wants to provide are offered by a variety of community-based organizations, the HMO is likely to prefer dealing directly with a single organization representing the community-based organizations rather than a number of separate organizations.

Licensure Requirements

In most states, HMOs are required to be licensed to contract with the state Medicaid agency to provide services on an at-risk basis. Usually, the state's Department of Insurance assumes the lead role in overseeing the

HMO's operations, including its benefits, marketing practices, and fiscal soundness. The Department of Health frequently oversees health-related requirements (e.g., accessibility and availability of the HMO's delivery system, quality assurance, and utilization review programs).

As part of their HMO oversight, many states require that the HMO's health delivery and administrative systems meet certain requirements. These requirements may apply to subcontractors such as the Healthy Start project. For example, the Healthy Start project may be required to cooperate in resolving member complaints, comply with confidentiality requirements, agree not to assert claims against members, and allow its records to be available upon audit by the state. Also, if the services being performed by the Healthy Start project require state licensure or certification, the HMO will need to ensure that these requirements have been met and are being maintained. To determine the applicability of these requirements, the Healthy Start project needs to check with the HMO or the state's regulatory agency(ies) overseeing the HMO's operations.

Medicaid Managed Care Program Requirements

For the Healthy Start project, Medicaid HMO requirements will be even more important than the commercial HMO requirements. Some state agencies that oversee HMO licensing requirements will let the state Medicaid agency be the principal or sole regulator of the HMO's Medicaid managed care program. Frequently, the HMO's Medicaid contract is overseen by an agency of state government other than the agency that oversees the state's HMO licensing requirements. This agency may be the state's Department of Human Services or a Department of Health component other than the one that oversees the HMO's commercial operations. The designated agency has been identified in an agreement between the state and HCFA. (A list of the state Medicaid agencies is included as Appendix E.)

HMO Delivery System Requirements

How an HMO delivers its health services will affect the way the Healthy Start project designs and markets its proposal. Staff model HMOs frequently prefer providing services through their own employees. It may be harder for a Healthy Start project to persuade a staff model HMO to contract for services, such as social case management services, that are directly related to services that the HMO provides in-house.

Proposals for case management or outreach services need to incorporate ways to coordinate reporting and approvals between the HMO and its physicians. If the HMO has delegated substantial responsibilities to large medical groups or physician-hospital joint ventures, the Healthy Start project's proposal may need to incorporate a role for that medical group or physician-hospital joint venture or direct its proposal to that group or venture.

Further, an HMO looking to expand its delivery system may value the Healthy Start project's contacts with primary care and specialty physicians in its target areas. Several Healthy Start projects currently have relationships with federally qualified health centers or other community-based providers. Increasingly, these organizations are pursuing HMO contracts. The Healthy Start projects may want to work with these community-based providers by developing joint proposals to contract with the HMOs. In developing these proposals, the project may want to coordinate with the state Title V program to ensure consistency with the Title V program's managed care initiatives.

5

BECOMING AN ATTRACTIVE PARTNER TO HMOs

Four broad strategies can be used to enhance the Healthy Start projects' attractiveness to HMOs. The more of these strategies the Healthy Start project can incorporate when developing or marketing a product, the more likely it is to get contracts with HMOs. One strategy is to demonstrate to the HMO that the Healthy Start project can help the HMO provide services (e.g., case management services) that the HMO is required to provide under its Medicaid contract. A second is to demonstrate how the Healthy Start project can help the HMO improve its performance on quality measures (e.g., early prenatal care, immunization rates) that are being used by state Medicaid agencies to evaluate the quality of care provided by HMOs. A third is to prove to the HMO that the Healthy Start project can provide services that result in lower medical costs. A final strategy is to generate revenue for the HMO by providing a new revenue source or increasing enrollment.

Helping HMOs Meet Contractual Requirements

HMOs are looking for partners who can help them fulfill their service delivery obligations. State managed care requirements are becoming increasingly detailed with regard to specific services and the level of services HMOs are required to provide to Medicaid beneficiaries. Because the childbearing population—women eligible for services through AFDC and the Sixth Omnibus Budget Reconciliation Act (SOBRA)—comprises the majority of the Medicaid population, many of the defined services are for maternal-infant care. Further, the federal government issues compliance targets for Early and

Periodic Screening, Diagnostic and Treatment (EPSDT), which states require HMOs to meet. Healthy Start projects can help HMOs meet their service delivery requirements in a number of ways: The Healthy Start project could (1) provide case management services or transportation to HMOs in states that require HMOs to provide such services to Medicaid beneficiaries; (2) ensure that beneficiaries obtain preventive care, such as immunizations; and (3) collaborate with health care providers in areas where HMOs need to build their health care provider networks (e.g., rural or new service areas).

Helping HMOs Perform Well on Quality Measures

Healthy Start projects should (1) be aware of the quality measurement tools that will be used to evaluate the HMOs that they are approaching, and (2) determine how the project can assist the HMO in performing well on those measures. States are increasingly using quality measurement tools to evaluate the performance of HMOs and help consumers choose between HMOs based on the quality of care provided. Consequently, performing well on these measures is important to HMOs. The quality of services that an HMO provides affects its reputation.

States are using a variety of tools for quality measurement. In February 1996, the National Committee for Quality Assurance (NCQA) published specific Medicaid indicators that state Medicaid agencies can use to evaluate the quality of services provided by Medicaid HMOs. The standards are known as Medicaid HEDIS (Health Plan Employer Data and Information Set—the Medicaid version was adapted from an instrument designed to provide employers with a tool to measure quality of care delivered by HMOs to their employees). While only a handful of states (including Texas, Michigan, and Florida) are currently using the Medicaid HEDIS measures in whole or part, Medicaid HEDIS is considered to be a state-of-the-art tool for measuring the quality of care provided by HMOs to Medicaid beneficiaries.

A new quality measurement document, HEDIS 3.0, was published in January 1997. HEDIS 3.0 was designed to provide one measurement instrument for the commercial, Medicaid, and Medicare populations and supersedes Medicaid HEDIS. However, the Medicaid-specific measures in HEDIS 3.0 are substantially the same as those in Medicaid HEDIS. In fall 1996, HMOs received the specifications to prepare their information systems to provide information on the HEDIS 3.0 measures. States that have not yet developed a quality measurement tool may require reporting based on the HEDIS 3.0 indicators.

Healthy Start projects should become familiar with Medicaid HEDIS or the Medicaid measures in HEDIS 3.0 because HMOs are familiar with the instruments. The measures included in both instruments are representative of the types of quality information states are requiring HMOs to report.

In the introduction to the initiation of prenatal care measurement, the Medicaid HEDIS document states that "prenatal care consists of three components: (1) early and continuing risk assessment; (2) health promotion; and (3) medical and psychosocial interventions and follow-ups." Healthy Start projects can support plans in their efforts to ensure that pregnant women receive all three components of prenatal care. Through education and outreach, Healthy Start can emphasize the importance of early prenatal care. The project can facilitate use of prenatal care through support services such as transportation and child care. In addition, trained outreach workers are ideally positioned to provide ongoing education and assessment of psychosocial risks.

Healthy Start projects can also help HMOs reduce low birthweight deliveries. In the introduction to the low birthweight measure, the Medicaid HEDIS document discusses a Packard Foundation study that concludes that "the ultimate success of prenatal care in substantially reducing current low birthweight in the U.S. may hinge on the development of a much broader and more unified conception of prenatal care than currently prevails"

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(*The Future of Children: Low Birthweight*, Packard Foundation, 1995). By combining and integrating the social and support services offered by Healthy Start with the medical services offered by HMOs, HMOs and Healthy Start can partner to offer this broader concept of prenatal care.

In addition, Healthy Start projects can improve an HMO's performance on Medicaid HEDIS measures through outreach and education functions that ensure that infants and young children receive immunizations and routine child health supervision. Healthy Start projects' facilitating services such as transportation and child care can enhance access to care. Under the general plan management measure, contracts with Healthy Start projects can strengthen an HMO's case management program by providing a social case management component and fulfill the Medicaid HEDIS suggestion for arrangements with public health, education, and social service agencies. Finally, the additional attention and personal services provided through a Healthy Start project will improve enrollee satisfaction.

Lark Kent has learned that New Medicaid HMO has been having difficulty in getting its enrollees to obtain preventive care such as prenatal care and immunizations. New Medicaid HMO representatives have told Lark that they believe that the enrollees know about the need for the visits through information given at the time of enrollment and periodic mailings. Lark suggests providing the services at the Healthy Start project's centers where Medicaid beneficiaries can do "one-stop shopping." She knows that many beneficiaries visit these centers to receive their WIC vouchers and that the Healthy Start project's case managers are based in the centers. New Medicaid HMO representatives believe that the arrangement may increase access to preventive care and compliance with immunization schedules.

Helping HMOs Reduce Costs

HMOs are interested in contract partners who can help reduce costs. Therefore, evidence demonstrating that the Healthy Start project can reduce maternity and infant care costs would be attractive to HMOs. If the project does not have direct evidence of cost savings, it may still demonstrate the effectiveness and efficiency of proposed services through outcome measures such as gestational age, birthweight, and neonatal intensive care unit days. When calculating cost-effectiveness, it is important to use local statistics to the degree possible so that HMOs can see the impact the services would have on their costs and their enrollees. Further, because many HMOs have limited case management programs, it would be helpful for Healthy Start projects offering case management/care coordination services to demonstrate the impact on costs and health from more intensive case management services. Because HMO case management programs frequently focus on medical case management, the Healthy Start project needs to ensure that it and the HMO have the same definition of the scope of case management. The Healthy Start project can also assist the HMO in reducing administrative costs by serving as a single point of contact for a number of subcontracting entities. Moreover, it may be more cost-effective for an HMO to contract for a service rather than provide it directly.

Helping HMOs Increase Revenue

Healthy Start projects can help HMOs increase revenue by helping the HMO increase and retain enrollment and/or by creating a new revenue source. An HMO's success is dependent on attracting members. To attract members, the HMO engages in both direct and indirect marketing. Direct marketing may include advertisements, commercials, and other media activities. Indirect marketing occurs when the HMO engages in activities, such as developing relationships with community-based organizations or sponsoring community projects or events, that enhance its reputation. HMOs frequently view relationships with the Healthy Start project as an important marketing advantage. This is particularly important in states that limit the range of direct marketing activities in which HMOs may engage. Because many of the Healthy Start projects have a good reputation in the beneficiary community, HMOs can attract enrollees by providing access to their traditional providers through the Healthy Start project. Further, the project can help the HMO retain enrollees since women who have relationships with case managers or outreach workers through the HMO are likely to want to retain those relationships.

Healthy Start projects can also help HMOs increase revenue by providing a new revenue source. For example, states may carve out certain services from the capitation payment to HMOs. These services are frequently paid for on a fee-for-service basis. If the HMO can provide these services through a contract with Healthy Start, the HMO will receive additional revenue from the state.

In Metropolis, the state provides reimbursement for prenatal case management and education separately from the capitation payment to HMOs. Metropolis Healthy Start knows that it can qualify as a provider of these services and receive direct reimbursement from the state. However, reimbursement from the state is slow and unpredictable and Metropolis Healthy Start does not have a source that refers women to the Healthy Start project for the services. Lark Kent proposes to Old Medicaid HMO that, in exchange for a certain volume of referrals from the HMO, Metropolis Healthy Start would be willing to have Old Medicaid HMO receive the payments from the state, retain a portion to cover its administrative expenses, and pay Metropolis Healthy Start. Under this arrangement, Metropolis Healthy Start's client load would increase and the Healthy Start project would have a predictable, steady source of income.

6

PREPARING TO ACT AS A CONTRACTOR TO HMOs

Each Healthy Start project will have to determine the scope of the relationship it is prepared to enter with HMOs. An important part of making this determination is evaluating the project's ability and preparedness to act as a provider of services to an HMO.

Organizational Structure

An initial issue that each Healthy Start project will need to resolve is which organization will contract with HMOs to provide Healthy Start services. This issue determines the organization that is ultimately responsible for performance of the contract and the quality of the services provided to the HMO. The principal options are that the HMO would contract with (1) the Healthy Start project or grantee organization directly, (2) the Healthy Start project's subcontractors directly, or (3) a new organization that negotiates on behalf of the subcontractors and/or the Healthy Start project.

Healthy Start Project or Grantee Organization as Contractor

Under this option the Healthy Start project or grantee can provide services to the HMO or can act as an intermediary organization to contract with the HMO on behalf of subcontracting organizations. An important factor to consider is whether the Healthy Start grantee organization envisions itself continuing its direct involvement in providing Healthy Start services and whether the nature of the grantee organization lends itself to that role. For example, if the grantee is a government entity, governmental rules may make it difficult for the Healthy Start project to perform its obligations as quickly or as efficiently as a private organization. In such a case, the Healthy Start project may want to form a new organization separate from the grantee to facilitate its ability to contract with HMOs.

Healthy Start Subcontracting Providers as Contractors

If the Healthy Start subcontracting organizations decide to contract directly with HMOs, the Healthy Start project should determine the amount of assistance it will provide to help the subcontractors obtain HMO contracts. Such assistance can range from promoting the subcontracting organizations through marketing techniques to negotiating with HMOs on behalf of the subcontractors. One variation of this option is to have a subcontracting organization contract with HMOs not only on its own behalf but on behalf of other subcontractors as well—in effect, the subcontractor would act as the intermediary organization.

This strategy works best where the subcontractors are large organizations (unless an intermediary organization approach is used). Typically, HMOs prefer to avoid administering contracts and providing oversight to a number of small contractors. As a result, HMOs generally look for contractors that can provide a range of services or an intermediary organization that will serve as a single point of contact for a number of smaller organizations.

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New Tax Exempt Organization as Contractor

The Healthy Start project and its subcontractors may want to form a new tax-exempt organization to contract with the HMO. This possibility may arise if no single existing organization is capable of representing all of the organizations that want to offer services to the HMO. In this instance, the Healthy Start project needs to give careful thought to how this new organization is funded and its long-term mission. A key issue to resolve is how the Healthy Start project and its subcontractors will allocate control and financing of the new organization. In addition, a determination needs to be made regarding whether the new organization would qualify for tax-exempt status.

Providing Services Through Subcontracting Organizations

If the organization that contracts with HMOs (for simplicity, the contracting organization is hereafter referred to as the Healthy Start project) provides some or all services through subcontractors, the Healthy Start project would act as an intermediary organization or agent for its subcontractors in the contract negotiations. Healthy Start projects subcontracting with a number of organizations to provide services need to resolve several issues before contracting with HMOs. First, the Healthy Start project needs to determine the willingness and ability of its subcontracting organizations to collaborate in obtaining managed care contracts. Some larger or more sophisticated subcontracting organizations may be interested in directly pursuing managed care contracts. These organizations may choose to work with the Healthy Start project on a nonexclusive basis and continue independently pursuing managed care contracts. Other subcontracting organizations may not have the ability to obtain managed care contracts independently and will be dependent on collaboration with the Healthy Start project and other subcontracting organizations to obtain contracts. The Healthy Start project should discuss with subcontractors potential relationships with the project and other subcontracting organizations.

Second, the Healthy Start project may need to limit the number of organizations with which it ultimately works. Some subcontractors will be more prepared to work with HMOs than others. These contractors may be larger and have more of an ability to operate as a business. In addition, some contractors will be more attractive or marketable to HMOs.

Finally, if different subcontractors are providing the same kinds of services, there needs to be a mechanism for standardizing the service across

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the HMO's service area. The Healthy Start project and subcontracting organizations will need to work together to determine the protocols for providing services for HMOs to the extent that the services or requirements differ from those offered under the Healthy Start program. All subcontracting organizations providing a particular service will need to follow the agreed upon protocols to ensure that enrollees of a particular HMO receive the same services.

Establishing and maintaining a good relationship with the subcontractors is critical to the success of the managed care initiative. Under a contract with an HMO, the Healthy Start project will be ultimately responsible for the performance of its subcontractors. The Healthy Start project will be representing to the HMO that its subcontractors are legally obligated and capable of fulfilling their respective obligations.

For purposes of providing services to an HMO, the Healthy Start project will need to enter into a separate agreement with each subcontractor. (A sample agreement between a Healthy Start project and a subcontractor specifically for providing services to HMOs is provided in Appendix D. Note the broad language obligating the subcontractor to accept the terms agreed to between the HMO and the Healthy Start project.) The Healthy Start project needs to ensure that its subcontractors are aware of the range of provisions that the subcontractor will be obligated to meet. If the subcontractor wants to place limits on the discretion given to the Healthy Start project to negotiate on the subcontractor's behalf, those limits need to be carefully discussed between the Healthy Start project and the subcontractor.

If the Healthy Start project is coordinating the services that are provided by its subcontractors, the agreement between the Healthy Start project and the subcontractors needs to identify how the Healthy Start project will be compensated for these services. Frequently, organizations that assume an administrative role retain a percentage of the revenues to fund their administrative costs. This arrangement assumes that the Healthy Start project receives the funds directly from the HMO and then distributes the funds to its subcontractors.

Administration

In preparation for contractual relationships with HMOs, the Healthy Start project may need to modify its administration to operate more like a business. First, the Healthy Start project should consider whether its administration is efficient. Paring back administrative functions will allow the project to offer services at more competitive prices. The Healthy Start project should also develop some kind of response mechanism that will allow it to react promptly to the HMO's needs. The Healthy Start project should ensure that the lines of command are clearly defined so that the project can contract in a timely manner and respond to HMO requests. Further, the Healthy Start project should determine who has the authority to make decisions or answer the HMO's questions.

State Requirements for Organizations Contracting with HMOs

The state may have a number of requirements for HMOs that apply to any of their subcontractors. The Healthy Start project should contact the state Medicaid agency to determine the standards with which the Healthy Start project would be required to comply as a subcontractor to an HMO. Further, the Healthy Start project should evaluate its ability to meet the requirements and begin developing the appropriate systems to do so. These requirements vary by state and may include:

- Maintaining records in a certain manner and for a certain period of time
- Complying with state Medicaid agency audit requirements
- Complying with quality assurance responsibilities (including conducting member satisfaction surveys, following up those surveys, and meeting certain certification requirements)

- Complying with requirements that subcontractors retain a staff representative of the communities they serve
- Complying with language proficiency requirements
- Complying with applicable requirements for facility access for persons with physical disabilities
- Complying with requirements for tracking complaints and grievances
- Complying with requirements that the Healthy Start project fulfill its obligations appropriately and in a timely manner

Providing Services to HMO Enrollees

The Healthy Start project needs to consider the implications of providing services to HMO enrollees as distinct from providing services to the community as a whole. While the Healthy Start project may continue to provide services to the community through other sources of funding, the project will need to distinguish its HMO clients. It also may need to be able to determine whether clients are enrolled in the HMO, in order to be reimbursed.

Further, the Healthy Start project should consider whether providing services to HMOs fits within its mission. If the Healthy Start project is a tax-exempt organization, it should determine whether its relationship with HMOs fits within its basis for tax exemption. If not, the revenue that the Healthy Start project receives could be considered unrelated business income and be subject to taxes. Tax-exempt Healthy Start projects should consult with a tax attorney to resolve this issue.

7

STRATEGIC PLANNING: HOW TO DECIDE WHAT SERVICES TO OFFER TO HMOs

The Healthy Start project, in conjunction with its participating subcontracting service providers, needs to determine how the contractual arrangement with each HMO will be structured and which services will be offered to the HMO. A careful planning process needs to be used. This process entails several steps:

- Developing a mission statement that acknowledges the Healthy Start project's place in a managed care environment
- Developing a tentative list of services the Healthy Start project may want to offer the HMOs
- Evaluating the Medicaid HMOs and their needs in the Healthy Start project's community
- Determining the most appropriate organizational structure for offering services to HMOs
- Reevaluating the services to be offered to the HMOs

Developing a Mission Statement

Healthy Start projects should develop a mission statement identifying their underlying goals and objectives within the managed care environment. The mission statement should reflect the project's commitment to promoting maternal and child health and reducing infant mortality. At the same time, the mission statement needs to acknowledge that the Healthy Start project will be acting under the HMO's direction in providing services to the HMO's enrollees. The services provided by the Healthy Start project need to fit within the HMO's organizational structure and to complement, not duplicate, the HMO's services. The Healthy Start project needs to ensure that this mission statement is compatible with the objectives of the other activities of the Healthy Start project.

Developing a Tentative List of Services to Be Offered to HMOs

Consistent with its mission statement and in cooperation with its subcontractors, the Healthy Start project needs to develop an initial list of services that it will offer to HMOs. This process will involve listing all services currently provided or funded by the Healthy Start project, evaluating those services, and removing any services that the Healthy Start project initially concludes:

1. Are not successful;
2. Will not be of interest to HMOs, such as a program that is very costly or cannot be focused on the HMO's enrolled population;
3. Cannot be provided because neither the Healthy Start project nor the subcontracting service provider has the administrative capacity; or
4. Cannot be provided because the provider of that service is not interested in offering it to the HMOs.

The remaining list of services will provide the basis for further consideration by the Healthy Start project. For each service, the Healthy Start project should identify who will provide the service and whether the service can be provided to all HMO enrollees.

Researching the HMOs to Determine Their Needs and Their Perceptions of the Healthy Start Project and Initial Meeting

Another step in the planning process is to find out more about the HMOs, their needs and operations, and their perceptions of the Healthy Start project. The project needs to gather general information about the HMOs and the Medicaid managed care program. The project should then request a preliminary meeting to introduce the Healthy Start project to the HMO and to obtain more information regarding its organization, operations, and perceived needs for Healthy Start services.

Information Gathering

The Healthy Start project should begin by reviewing all available information from the state Medicaid agency about its Medicaid managed care program. This information could include a Request for Proposal identifying the requirements for the Medicaid program, a draft or actual HMO contract, and any other information deemed appropriate. These materials should be read carefully to identify all information directly related to the services that the Healthy Start project has tentatively decided to propose to the HMO. This includes:

- Information concerning whether (or in what manner) the HMO has any obligation to provide any Healthy Start-type services;
- Information concerning whether the Medicaid program carves out (pays separately for) any of the Healthy Start services; and
- Any general information (e.g., reporting requirements, credentialing requirements for case managers, or quality assurance requirements) that may affect the HMO's interest and ability to contract.

Another issue that the Healthy Start project should explore is whether the capitation rates paid by the state Medicaid agency to the HMO are perceived as adequate. This issue bears on whether the HMO believes it has adequate resources to fund Healthy Start services that it is not obligated to provide under its contract with the state Medicaid agency.

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The Healthy Start project could explore the reputation of the HMO by contacting hospitals and physician groups that contract with the HMO to gain information concerning members' perceptions of whether their health needs are being met, overall perceptions about the quality of care provided by the HMO, and timeliness in payment of claims. The Healthy Start project needs to be sensitive to the detrimental effects of associating with an HMO that does not have a good reputation in the community.

It is worthwhile for the Healthy Start project to estimate how large a Medicaid enrollment the principal HMOs are expected to receive. If the Healthy Start project is not willing to contract with all HMOs, one important selection criterion is whether a particular HMO is expected to be successful in a mandatory Medicaid managed care environment. Further, independently assessing an HMO's enrollment potential offers the Healthy Start project a check on the HMO's projections and may provide a more realistic assessment of the level of services that the Healthy Start project would need to be able to provide if it entered into a contract with the HMO.

Preliminary Meeting with the HMO

A preliminary meeting with the HMO can serve to introduce or to reacquaint the Healthy Start project and the HMO; find out the HMO's level of interest in the project's services; and make an independent assessment of the type of services that the HMO might or should be willing to obtain and how the delivery of those services could be coordinated with the existing operations of the HMO.

The appropriate HMO representatives with which to meet will vary depending on the size and structure of the HMO, the relative importance of the Medicaid product, and whether the Healthy Start project has current relationships with HMO representatives.

In many cases, Lark Kent and other representatives of Metropolis Healthy Start will want to meet with the director of Medicaid operations and a manager of clinical services responsible for obstetrics and prenatal care. The Director of Health Services reports to the Medical Director, who is responsible for programs that need to be case managed. Because New Medicaid HMO is relatively small and Medicaid services will be its most important product, it may be more appropriate for the Metropolis Healthy Start to meet with the Chief Executive Officer or Chief Operating Officer of New Medicaid HMO.

Background

Demonstrating to the HMO representatives that the Healthy Start project is familiar with the HMO conveys a businesslike approach. Therefore, the project will need some background information on the HMO. Prior to the meeting, the Healthy Start project should obtain the following information from the state Medicaid agency and/or the Department of Insurance (or other agency responsible for licensing HMOs):

- How long has the HMO had a Medicaid contract or when does it expect to receive one? If the HMO has a long-standing program, the Healthy Start project will need to focus attention on finding ways to fit into the HMO's existing operational structure. If the HMO does not have a contract and is in the process of designing and developing a delivery system, it may be more receptive to a proposal that includes a broad range of services.
- Is the HMO a nonprofit or for-profit entity? For-profit HMOs, which are seeking a return on investment, may demand clearer substantiation of the cost-effectiveness of the Healthy Start project interventions being offered than nonprofit HMOs would demand.
- How many enrollees does the HMO have? Enrollment size bears on two issues. First, a large HMO may be more attractive to the Healthy Start project because it offers the opportunity for larger revenues. The large HMO may be more economically viable because it has smaller administrative costs per enrollee than smaller HMOs. On the other hand, the Healthy Start project needs to ascertain whether it has the capability to provide the services it hopes to offer the HMO. The larger the HMO, the greater the project's resources needed to meet the HMO's needs.
- Are Medicaid revenues a large portion of the HMO's total revenues? If not otherwise available, this information can be roughly determined by comparing the size of the HMO's Medicaid enrollment with its other enrollment. If the Medicaid program is the sole product of the HMO, the HMO may be more interested in exploring nonmedical

interventions that can help control its costs. In addition, the HMO is likely to be more familiar with the value of outreach and intensive case management/care coordination services. However, an HMO with a large, stable commercial enrollment may be more willing and able to expend funds initially to develop comprehensive prenatal programs than start-up Medicaid-only HMOs.

Questions about the HMO

At the meeting or meetings with the HMO, Healthy Start representatives should try to learn:

- Who is the person within the HMO with the authority to make the decision to contract with the Healthy Start project and who within the HMO will principally influence that decision?
- Is the HMO familiar with the Healthy Start project? If the Healthy Start project anticipates that the HMO is not familiar with the Healthy Start project, it should be prepared to provide an overview of the project's activities and successes.
- What is the HMO's perception of the Healthy Start project and the subcontracting service providers? If the perception is negative, the Healthy Start project needs to focus its attention on understanding the basis for this negative impression. Otherwise, these perceptions will seriously diminish the likelihood that the Healthy Start project will be able to contract with the HMO.
- How does the HMO deliver services (e.g., employed physicians, contracts with individual physicians, contracts with medical groups)? The Healthy Start project should also know how the physicians are paid. This information should allow the project to learn whether the HMO gains directly in the short term from cost savings arising from Healthy Start project interventions. If physicians (rather than the HMO) are at financial risk for bad outcomes, there is less economic incentive for the HMO to contract with Healthy Start. This information will also assist the Healthy Start project in learning the extent to which it will be interacting with non-HMO staff and the difficulties that may arise in obtaining the cooperation of the HMO's physicians.
- How much growth does the HMO expect in its Medicaid enrollment, or, if the HMO is just beginning to enroll beneficiaries, what size does the HMO expect its Medicaid enrollment to be?

- Does the HMO have linkages with other organizations, such as federally qualified health centers? The Healthy Start project may want to integrate its services with the health and other enabling services provided by these organizations.
- What is the approved service area in which the HMO will provide (or intends to provide) services to its Medicaid enrollment? This service area may differ from the area in which the HMO provides services to its commercial population. The Healthy Start project needs to determine whether it is able to provide its proposed services to the HMO's entire service area. If appropriate, the preliminary meeting could be used as an opportunity to explore the HMO's reaction to potential program sites proposed by the Healthy Start project.
- What is the HMO's level of utilization for hospital stays (hospital days per 1,000) and neonatal intensive care unit stays? This information can be compared with Healthy Start data. The Healthy Start project should be prepared to discuss the appropriate standards for a Medicaid population, including the benchmark in the state, the average length of stay for cesarean section deliveries and for vaginal deliveries, and how many births per thousand varied by case mix.

Questions about Case Management and Facilitating Services Currently Offered by the HMO

The project needs to determine whether the HMO is already providing case management and facilitating services to pregnant women and newborns. If so, the Healthy Start project should acquire detailed information about these services. This information will help the Healthy Start project determine how its services fit with the services already offered by the HMO or how to offer higher quality or more cost-effective services than those currently being provided. Questions to ask include:

- What kind of pregnancy-related and newborn services does the HMO offer (e.g., outreach, case management, counseling, educational programs)? The fact that an HMO currently provides a particular service does not mean that the HMO would not be interested in contracting with Healthy Start to provide the service if the Healthy Start project can provide it more cost effectively.
- Are the HMO's existing programs designed to serve its commercial enrollment and/or Medicaid enrollment?
- Does the HMO's case management program incorporate social

services? Does the case management program require prior authorization or precertification? At what point do the existing services receive case management?

- Are the Healthy Start-type services currently offered by the HMO being provided by HMO staff or independent contractors (i.e., an outside organization with which the HMO has a contract)? How many staff does the HMO assign to case management and outreach services and what are the qualifications of the staff performing these functions? This question allows the Healthy Start project to estimate the costs and administrative burdens incurred in providing the current services.

In addition to finding out about the Healthy Start services currently provided by the HMO, the project needs to learn about the HMO's perception of the value of the Healthy Start services. Does the HMO view the services as worthwhile? If the HMO believes the services are worthwhile, is it because the Healthy Start interventions will result in a reduction of the HMO's health care costs or is there another reason?

General Points About the Meeting

All of the previous questions are intended to give the Healthy Start project an initial understanding of whether it will need to revise its proposed services to complement the services offered by the HMO and to convey to the HMO its knowledge of the issues. In addition, the questions allow the project to learn whether the HMO views itself as already offering the majority of the

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services that may be offered by the Healthy Start project. The project needs to keep in mind that the HMO may not fully appreciate the differences in the type of case management that the HMO currently provides and the type offered by the Healthy Start project.

In the meeting with the HMO, the Healthy Start project should carefully assess the personal reactions of the HMO staff. The Healthy Start project is seeking to gauge not only the reactions of the HMO but also the reactions of the individuals with whom the project staff meet. The HMO staff representatives may be more sympathetic to Healthy Start than the final decision maker within the HMO. The meeting is an opportunity to obtain informal advice from a middle management HMO representative regarding how to influence the key decision makers within the HMO.

The Healthy Start project should be prepared to identify some of its successes at the preliminary meeting with the HMO (e.g., the project's success rate in locating pregnant women and persuading them to obtain prenatal care). The Healthy Start project should also begin discussion of the value of its services, explaining that the cost of purchasing the services will be more than offset by savings in health care costs or improved outcomes. The project could identify outcome measures such as shorter lengths of stay after births or fewer cesarean section deliveries, and discuss how Healthy Start interventions improve those outcomes.

Moreover, the Healthy Start project should be prepared to discuss its initial ideas for providing services to obtain feedback from the HMO. Healthy Start project representatives should feel comfortable in informing HMO staff that they are in the preliminary stages of a proposal and are looking for input. The HMO may suggest that the project propose services it had not previously envisioned. At the meeting, the project should be sufficiently receptive to consider this possibility.

During the preliminary meeting with Old Medicaid HMO, HMO representatives become interested in the possible uses of Metropolis Healthy Start's case managers and outreach workers. Enrollees of Old Medicaid HMO have been inappropriately using the emergency room, which is expensive for the HMO. Old Medicaid HMO suggests that it could provide Metropolis Healthy Start with a list of persons who have a pattern of inappropriate emergency room use. Healthy Start could send outreach

workers to visit these persons to determine whether there was a problem and to provide education in how to access health care services appropriately. The outreach workers would provide referrals to case managers when follow-up was needed. Lark Kent realizes that while the proposed service does not necessarily serve the Healthy Start project's goal of improving birth outcomes, the project could use revenue from providing this service to the HMO to fund the maternal-child health services that the project provides to community clients.

Evaluating the HMO

The Healthy Start project should use the preliminary meeting to decide whether it wants to contract with the HMO based on its business dealings, reputation, or compliance with legal requirements. The following issues may affect this decision. Healthy Start project staff can research some of this information through the Department of Insurance or state Medicaid agency, and use the meeting to obtain the information that was not available through other sources and/or to follow up on their findings.

- Is the HMO currently in full compliance with all applicable licensure and Medicaid requirements?
- What is the HMO's disenrollment rate and how does that rate compare with the disenrollment rate of other HMOs in the area?
- How frequently does the HMO receive member grievances and complaints, and how does that frequency compare with the corresponding rate of other HMOs in the area?
- How frequently does the HMO fail to pay its service providers within the period identified in its contracts or the period required under Medicaid law? (The Healthy Start project may want to talk to other providers contracting with the HMO to get this information.) Does the state require payment of claims within a specified period of time? If so, how will the Healthy Start project track this?
- What is the HMO's relative position in the marketplace? Which other HMOs does it view as its chief competitors and what factors may influence the success or failure of the HMO's Medicaid product?

Refining the List of Services to Be Offered to the HMOs

After gathering information on the particular HMO and meeting with its representatives, the Healthy Start project needs to refine its initial list of possible services to develop its proposal. This process includes several steps. First, the Healthy Start project should exclude services that the HMO clearly does not want. The project may still want to retain in its proposal some services that initially do not appear to interest the HMO, but that the project representatives believe may interest the HMO at a later time. Second, the Healthy Start project should refine the list of services by narrowing down aspects of services that the HMO itself already offers or is clearly unwilling to purchase from the Healthy Start project. Finally, the Healthy Start project should expand the list or add services to the list based on conversations with the HMO. For example, if the HMO suggests the need for outreach services to a Medicaid population not currently covered by the Healthy Start project, the Healthy Start project needs to decide whether it will incorporate that service.

Determining the Healthy Start Project's Ability to Provide the Proposed Services

The next step in the process is for the Healthy Start project to evaluate whether it is capable of providing the volume of services needed by the HMO. The project should consider the following issues:

- Does the Healthy Start project have enough staff with the appropriate qualifications to meet the needs of the HMO? If not, the Healthy Start project needs to recruit and train the necessary staff to perform these services in a timely manner.
- Can the Healthy Start project provide the services to the enrollees residing in the entire service area of the HMO, or at least the areas where a majority of the HMO's enrollment resides? If not, the project should determine whether it can expand its scope of services to cover the HMO's entire service area. If the HMO is interested in a pilot/demonstration project initially, this will not be an issue. However, HMOs generally want enrollees with the same eligibility status to have access to the same services.
- Do the Healthy Start project and its subcontractors have the necessary administrative infrastructure not only to provide the services, but to monitor the performance of its obligations and provide the reports required by the HMO?

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- Is it economically feasible to offer each of the services? Although it may be difficult, the Healthy Start project needs to evaluate its costs. A project has direct costs such as salary for case managers, and indirect costs such as rent for its building. Is the project able to offer a proposal that recovers both its direct and indirect costs? A Healthy Start project may have more flexibility in pricing for a particular service if that service is already being funded through another revenue source. Then, the project is not forced to rely on revenue from the HMO to cover all of the costs of the service. The project should also be aware that its pricing strategy is very dependent on the HMO's perception of whether the Healthy Start interventions will result in substantial cost savings to the HMO. If so, the HMO might be willing to pay the Healthy Start project an amount that far exceeds the project's actual costs for providing the services.

While the compensation from the HMO is negotiable, it may be clear to the Healthy Start project that the revenue required to provide a particular service far exceeds the amount the HMO would be willing to pay for this service. In such a case, the service should be removed from consideration.

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DEVELOPING AND MARKETING A MANAGED CARE PROPOSAL

Developing a Managed Care Proposal

In developing a managed care proposal, the Healthy Start project should be aware of several key points. First, the HMO will assume that many elements of the project proposal, particularly the price, are negotiable. In developing its package of services offered and the pricing for these services, the Healthy Start project needs to carefully consider fallback positions in case the HMO rejects the initial proposal.

The project may want to accompany a proposal with a suggestion that the HMO enter into a nonbinding letter of intent with the Healthy Start project. This letter may be attractive to the HMO if it will enhance the HMO's likelihood of success in obtaining a Medicaid contract. While this letter of intent is not binding on the HMO, it can be used by the Healthy Start project to encourage the HMO to continue negotiations.

A proposal to an HMO could be a formal contract or an informal letter. Ideally, a proposal will contain a concise statement of the key elements, such as the services that will be offered and the price. The summary could be followed by either a more detailed discussion of the proposal's elements or a draft contract. In either case, the supplemental document should contain most or all of the key substantive provisions that define the relationship.

While a key purpose of the preliminary meeting is for the Healthy Start project to learn about the HMO, another key objective is to use the meeting as an opportunity to convey to the HMO a favorable impression of the Healthy Start project. It is preferable for the Healthy Start project to have this opportunity before submitting a proposal.

Packaging the Healthy Start Project Services

As a result of the planning process, the Healthy Start project will develop a list of services to offer to the HMO. A fundamental issue for the Healthy Start project involves how the services will be packaged.

Providing a range of options. One option is to offer the HMO a range of individual options from which to choose. For example, the Healthy Start project could offer the HMO several types of case management or outreach services, educational programs, male outreach programs, and transportation programs.

Packaging sets of services. A second option for the Healthy Start project is to package a core set of services that must be bought collectively (e.g., outreach and case management services). Rather than offer a range of different outreach and case management services, the Healthy Start project would develop a single comprehensive program and offer that program to the HMO. Other services that are not part of the core services would be offered separately to the HMO. The Healthy Start project may decide to offer the supplemental services only if the HMO is willing to purchase the core services.

Providing HMOs the option to purchase certain services at a later point in the contract. A third option is to create a category of services that the HMO may not want to purchase initially, but would want the option of purchasing during the contract term. The needs of HMOs change over time. By including the additional nonselected services as a future option, it becomes easier for the HMO to add those services later. The Healthy Start project would not want to offer this third category of optional services unless the project had the desire and capability to add these services during the life of the contract.

Providing HMOs with the option to purchase services in groups or individually. A last option is for the Healthy Start project to give the HMO a range of options that would include purchasing services either in groups or individually. This option gives the HMO maximum flexibility. However, the Healthy Start project may not want to give the HMO this much flexibility if it reduces the likelihood of attaining the project's most desired arrangement. If the Healthy Start project believes that the HMO is sufficiently interested to negotiate, the project can use less desirable arrangements as fallback options.

Pricing

Determining how to price Healthy Start project services is one of the most difficult parts of proposal development. Because accepted market prices do not exist for Healthy Start services and it is difficult to calculate their revenue requirements, projects are frequently reluctant to propose prices for their services. Several issues need to be considered carefully by the Healthy Start project in developing the prices for its products. Pricing has two perspectives: (1) the price the HMO is willing to pay for the services and the value of the services to the HMO, and (2) the price the Healthy Start project must charge for the services to ensure that the project and/or its subcontractors recover their costs.

If the HMO believes that substantial economic savings will occur from the Healthy Start services or that the services are necessary for the HMO to meet its contractual obligations to the state Medicaid agency, the HMO may be willing to pay far more than the project's costs to purchase the services. In contrast, if the HMO is uncertain as to the value of the services or if the Healthy Start project has a high cost structure, the HMO may not even be willing to pay the project's costs to purchase the services.

In determining its costs, the Healthy Start project needs to have a reasonable expectation of the volume of services that will be purchased. Typically, the Healthy Start project's per unit costs will decrease as the volume of services increases. What is a reasonable expectation of the volume of services? Ideally, the HMO will commit itself in its contract with the Healthy Start project to purchase a minimum level of services (e.g., case management services for a minimum number of pregnant women). If the HMO is unwilling to commit itself to a minimum purchase, the Healthy Start project needs to evaluate the likelihood that the amount of services purchased by the HMO will be sufficient to justify the project's efforts.

A critical part of the Healthy Start project's pricing involves identifying the unit of services that will be purchased for a specified price. The unit could consist of all needed services over a specific time period, a set number of services, or an individual service. The Healthy Start project may want to group services to increase the amount purchased by the HMO. However, the project needs to take care not to suggest more services than the HMO would be expected to want to purchase. For example, if the Healthy Start project is proposing to provide case management services, how long will the project provide those services to a client—for 120 days, for the length of the pregnancy, for the length of the pregnancy and a defined postpartum period? Has the project agreed to provide a set number of services (e.g., home visits) over this time period? For each period, the HMO could be obligated to pay the Healthy Start project the agreed-upon price.

Units of service may also be an issue for educational services. If the Healthy Start project offers educational programs, those programs could be grouped and the HMO could be obligated to pay for the entire group.

When pricing on other than a fee-for-service basis, the Healthy Start project needs to take care not to underestimate its costs by underestimating the needs of the HMO enrollees referred to it. This problem might arise if the Healthy Start project agrees to provide case management services to the HMO under the assumption that a large number of pregnant women of varying needs and risks will be referred to the Healthy Start project. However, the HMO may decide to refer only the highest-risk enrollees to the Healthy Start project, and the resources necessary to provide case management services to that population would be far greater than expected. To prevent this problem, the Healthy Start project could suggest dividing its offered case management services into several categories based on the amount of resources necessary to perform the services. The Healthy Start project could price the categories differently to ensure adequate payment if assigned an unexpectedly large proportion of very-high-risk enrollees. In devising such a system, the project should be careful to ensure that its structure is not too complicated to understand or administer. The Healthy Start project could consider establishing pricing arrangements that guarantee a minimum number of referrals or programs. A related option is to reduce its fees as the volume of referrals increases.

Another option for the project is a pricing arrangement that subsidizes less popular services. If an HMO wants to purchase outreach and case management services, but is less interested in educational programs, the Healthy Start project may want to increase the price of the case management/outreach services in order to provide the educational services at a very low price. At a low price, the HMO might be willing to purchase them.

A variety of administrative issues arise regarding payments and the performance of services. A detailed proposal will frequently address such issues as when the Healthy Start project can invoice for its services, or the HMO's obligations to pay on a regular basis without invoicing. Related issues to be included are how long the HMO has to pay the invoiced amount, what grounds might the HMO have to decline to pay the invoice, and whether interest accrues if the HMO fails to pay on time.

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Other Issues

Reporting requirements. The Healthy Start project will need to submit reports that identify the services provided or meet other requirements under the HMO's contract with the state Medicaid agency or the project's contract with the HMO. The Healthy Start project may want to take the initiative to develop sample formats for these reports.

A key issue is whether the HMO or the Healthy Start project has the right to determine the information required to be submitted and the format used to submit that information. Typically, the Healthy Start project will be required to submit information that is either required by the state or necessary to ensure that the project is performing its responsibilities appropriately. Many of these requirements are dictated by the state Medicaid agency, and the HMO will not have the discretion to waive them.

Because these information requirements may change over time, it is difficult to state expressly in the proposal/contract the exact information that needs to be provided by the Healthy Start project. HMOs frequently want to have the right to decide the format and the content of the submitted reports. The obvious problem with this arrangement is that the Healthy Start project will not be able to object to information requests that it believes are unduly burdensome or inappropriate. Healthy Start projects should consider the option of having the reporting requirements determined by the mutual consent of the HMO and the project. This compromise may meet the needs of both parties.

A related issue for the Healthy Start project is whether the subcontractors can provide the requested data. It is important for the project to work with the HMO and its subcontractors to ensure that the subcontractors fully understand and are willing and able to meet their responsibilities. The Healthy Start project should be aware that the state Medicaid agency may have sample forms for the project to review for consistency with its forms and for possible use.

An important financial issue for the Healthy Start project may be whether the HMO has any financial obligation for services provided to persons by the project when it is later determined that those persons were not eligible for Medicaid. One way to address this issue is to place the financial responsibility on the HMO (unless the Healthy Start project knew that those persons were ineligible for Medicaid prior to the time the services were provided).

Administrative coordination. An administrative issue concerns the form of HMO approval necessary to authorize the performance of services. Can the HMO's physician authorize case management services or is that right retained by the HMO? Who within the HMO has the authority to approve a service by the Healthy Start project? In what manner is the scheduling of services decided? Does the HMO or the Healthy Start project have the right to determine when and where classes are held or the exact type and quantity of services that are provided to persons assigned to case management? Some of these issues will be resolved by language in the contract. Some of these issues will be left for resolution after the contract is signed. However, the contract should clearly identify which party or parties have the responsibility to decide these coordination issues. The Healthy Start project should ensure that its subcontractors understand these responsibilities.

Termination, term, and amendment provisions. A basic issue for the Healthy Start project to consider is the length of the initial contract term. The first term of the contract is usually one year. However, the project may want the term of the contract to coincide with the term of the HMO's contract with the state Medicaid agency. Further, if the Healthy Start project is unsure about the economic feasibility of the arrangement, the project may want to suggest a pilot program for a shorter time period.

There are two types of contracts termination—for cause and without cause. Contracts almost always include provisions allowing a party to terminate for cause. The Healthy Start project should have the right to terminate the agreement if the HMO fails to meet its basic obligations under the contract, including the payment of amounts when due. The HMO typically has a number of grounds for allowing it to terminate for cause. The Healthy Start project will want the ability to correct any deficiencies identified by the HMO before allowing the HMO to terminate the contract for cause. This right reduces the likelihood that the HMO can terminate the contract because of a misunderstanding or on inappropriate grounds.

Amendments. An important issue is whether the Healthy Start project wants the right to terminate the contract without cause. If the project finds that it has entered into an arrangement in which it is sustaining substantial losses, it may want the right to terminate the contract prior to the end of the term. The drawback to this approach is that the HMO would also want to have the right to terminate the contract without cause. The Healthy Start project would not want the HMO to terminate the contract unilaterally after the project has invested a great deal of time and expense developing its program for the HMO. For this reason, it may be more desirable not to have a termination without cause provision in the contract during the initial term of the agreement.

Exclusivity. HMOs frequently want the right to amend agreements merely by giving their contractors written notice of the changes. Unless the contractor objects within a certain number of days, the contractor is deemed to accept the amendment. The Healthy Start project would not want a provision of this nature in its contract. It raises the possibility of the project unintentionally being obligated to accept changes dictated by the HMO.

Occasionally, HMOs will suggest that, if the Healthy Start project contracts exclusively with a single HMO, that HMO would be willing to contract with the project on terms more favorable than if the Healthy Start project contracted with multiple HMOs. This alternative is generally undesirable. The project is foreclosing the opportunity to work with other HMOs. If the selected HMO has a very small enrollment, the Healthy Start project may not be able to offer an economically viable program. Also, limiting the services to a single HMO seems to conflict with the underlying community-based objectives of the Healthy Start program.

Liability insurance. HMOs will request that the Healthy Start project have liability insurance. Sometimes the requirements for liability insurance are linked to community standards. During negotiations, the Healthy Start project should ensure that the HMO is not seeking insurance coverage that is more comprehensive than the project or its subcontractors currently have or need.

Confidentiality issues. The Healthy Start project will have the obligation to meet any applicable confidentiality requirements under state and federal law and any internal confidentiality requirements imposed by the HMO. To avoid any misunderstandings or the inappropriate release of information, the project should contact the HMO during the negotiations process to determine the applicable confidentiality requirements that the HMO must meet. If the HMO is asking the project to disclose enrollee information that the Healthy Start project believes might be confidential and not disclosable, the project should ask the HMO to document the basis for concluding that release of the information is legal.

The contract with the HMO will give the HMO, the state, and the federal government the right to audit the Healthy Start project and its subcontractors. In general, these provisions are fairly standard, and in some instances, required by law to be in the contract. If the Healthy Start project believes that the HMO is requesting access to some internal information that the project believes is proprietary and not needed by the HMO, the project should ask the HMO to substantiate its reasons for requesting that information. Also, the project needs to be aware of periods during which it must retain records. The Medicaid state agency can provide this information.

Dispute resolution/arbitration. Any disputes arising from the HMO's enrollees will need to be brought quickly to the attention of the HMO. The HMO will probably include a contract provision requiring the Healthy Start project to provide this information to the HMO. The contract may also obligate the Healthy Start project to cooperate in resolving any disputes. Disputes may also arise between the HMO and the project. The project should consider including a provision in the contract that encourages or requires the use of mediation or arbitration. Both forms of dispute resolution are less formal than litigation. Using these alternative dispute remedies results in fewer expenses and faster resolutions.

Operationalizing the Delivery of Services

To the extent that operational issues are outside the scope of a detailed proposal or a contract, the Healthy Start project should work closely with the HMO to develop written operational protocols, procedures, and work flows with appropriate points of contact, time frames, and benchmarks. Examples of issues that may be resolved are (1) whether the HMO has a clinical case manager to work with the Healthy Start project for referrals and to coordinate activities with the primary care physician; (2) whether some services require approval from the utilization management department; (3) whether the project has a time frame in which to perform its services; (4) when a Healthy

Start project can conclude that it is unable to find a particular Medicaid enrollee when attempting to provide outreach services; (5) whether there are standards regarding how many enrollees the project can reach within specified periods of time; (6) who the Healthy Start project's point of contact is in the HMO; and (7) how the project and the HMO will agree on forms for use by the Healthy Start project in performing its responsibilities.

Metropolis Healthy Start has agreed to provide health education and outreach services on a demonstration/pilot basis for Old Medicaid HMO. Under the contract, Metropolis Healthy Start will provide home visits and education on newborn health for women who inappropriately seek care for their newborns in emergency rooms. The parties have entered into a written contract but have several issues to resolve regarding how the program will be carried out. Lark Kent works with a representative of Old Medicaid HMO to determine how Metropolis Healthy Start will be notified of women with inappropriate emergency room use, how long after notification the project will have to contact the women, how the HMO will train outreach workers to teach women about the HMO's processes for accessing care, what mechanism the project will use for providing the HMO with requested data, and who at the HMO has the authority to make policy decisions about the contract.

Marketing a Managed Care Proposal

An enormous strength of the Healthy Start project is its reputation in its target area, along with its relationships with the leaders of other organizations providing services to the medically indigent. Both of these factors enhance the marketability of the Healthy Start project. The Healthy Start project needs to devise ways to ensure that HMOs are aware of these relationships. The project needs to evaluate its board, donor, and community contacts for assistance in promoting its services to HMOs.

In any marketing presentation or meeting where the Healthy Start project is promoting its services to an HMO, the project needs to highlight how it can address key underlying areas of concern to the HMO—cost-effectiveness, ways to enhance the HMO's marketability, ways to improve the report card rating of the HMO, compliance with regulatory requirements, and quality. The Healthy Start project should show how its proposal addresses each of these areas and should be prepared to answer questions. Further, the Healthy Start project needs to convey to the HMO that the project is there to help the HMO, not solely to support itself.

Appearance and manner of presentation are important. Proposals do not have to be elaborate or expensive, but should be clear, presented in a professional manner, and reflect a thorough understanding of the issues and concerns from the perspectives of the HMO and the project. Proposals should not include information about the Healthy Start project's costs. Health care providers do not typically provide cost data to HMOs during negotiations. Providing cost data may result in an HMO trying to negotiate a lower rate by criticizing the project's cost structure.

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PROPOSING AND NEGOTIATING A CONTRACT

The contract between the Healthy Start project and the HMO defines the legal responsibilities of the parties. While the Healthy Start project may be interested in entering into a less formal relationship in which details are negotiated as issues arise, projects should be aware that oral statements are generally not binding.

Appendices B and C provide two sample contracts between a Healthy Start project and an HMO. The first contract is quite detailed and is structured in a manner with which HMOs are familiar. The contract includes annotations explaining the reason for including or not including certain provisions. This contract could serve as a basis for either a proposal or a follow-up document after the Healthy Start project and the HMO have agreed to the basic terms of the arrangement.

The second contract is short and far simpler than the first. This form may be more suitable when the project is contracting with the HMO for one service that does not require detailed implementing or reporting requirements. If the Healthy Start project enters into a short contract with an HMO, the project should review the longer contract to ensure that key protections for the Healthy Start project have not been inappropriately omitted.

The key to successful negotiation of a contract is preparation. The most important part of the negotiation is for the Healthy Start project to develop a good proposal that draws on its strengths, provides underlying support for the value of its proposed services, and conveys to the HMO that the project is capable of performing both the administrative and substantive obligations under the contract.

It is important for the Healthy Start project to be confident in the meetings with HMOs. Always begin with the project's mission. The Healthy Start project needs to convey its knowledge of the value of its services—services that are needed by the HMO and worth the price suggested by the project. This approach may be difficult for Healthy Start project representatives who may not be accustomed to the managed care environment.

If the project proposes to offer the services of subcontractors, the Healthy Start project needs to have a contract with its subcontractors. (See Appendix D.)

The Healthy Start project must never lose sight of its objective—to close the deal. The project needs to develop and implement a strategy that continues to pursue obtaining the contract with the HMO. Finally, the Healthy Start project should always be willing to take the initiative.

Metropolis Healthy Start representatives have met several times with New Medicaid HMO staff to discuss opportunities for collaboration. Through these meetings, Metropolis Healthy Start has obtained information regarding the way that New Medicaid HMO typically works with its providers, and the types of services that New Medicaid HMO needs. As a result, Metropolis Healthy Start is ready to negotiate a contract with New Medicaid HMO. Based on the information obtained from the HMO, Metropolis Healthy Start presents a written proposal that includes the specific services Metropolis would like to provide, a fee for the services, and a structure for reporting to the HMO regarding services provided to its enrollees. The Metropolis Healthy Start proposal serves as a basis for its negotiations with New Medicaid HMO.

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ONGOING ISSUES

Obtaining a contract with an HMO is only the first step in a long process. Both the HMO and the Healthy Start project, as well as any Healthy Start subcontractors, need to work together to maintain a good relationship and to address issues that may arise during the life of the contract. Examples of some of these issues are:

Reporting. The reporting requirements are typically very imprecise. If the Healthy Start project believes that the reporting requirements of the HMO are inappropriate in content or format, the project should indicate this concern to the HMO. Frequently, the HMO's principal involvement with independent contractors is through entities that are providing health services. The HMO may want to impose requirements that are more applicable to providers of health services than social services. If such issues arise, they should be conveyed to the HMO.

Amending the contract. An important issue concerns when to propose an amendment to the contract. Generally, the parties entering into a contract intend to have the contract provisions apply for the term of the contract. However, circumstances not envisioned by the original contract may merit amending the contract, particularly when the Healthy Start project's actual costs for providing the services far exceed its projected costs. While the HMO may not be legally required to change the contract, the HMO might be willing to amend it if the project can justify the change.

Renegotiating the contract. Another issue involves renegotiating the contract at the end of the initial term. At least three or four months before the end of the contract term, the Healthy Start project should approach the HMO to discuss any changes that would apply if the contract is renewed. The project should be wary of waiting too long to raise issues or of HMOs that are delaying renegotiations. At the end of the contract year, the Healthy Start project does not want to be in the position of suddenly realizing that it no longer has a contract or that it is forced to continue to provide services under the existing contract.

Metropolis Healthy Start has been providing case management services under a pilot project with Commercial HMO for six months. Because the project is going well, Commercial HMO would like to double the number of enrollees obtaining services from Metropolis Healthy Start, and to develop a new system for identifying enrollees for whom Healthy Start will provide services. Because of the investment dollars needed for additional staff and for computer software, Healthy Start negotiates with Commercial HMO for a long-term contract with a guaranteed revenue stream. Thus, the people of Metropolis have a more integrated system of services, with the potential for long-term sustainability.

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CONCLUSION

Healthy Start projects have much to offer Medicaid HMOs. With organization and planning, most Healthy Start projects have excellent opportunities to collaborate with HMOs. The nature of the relationships between the projects and HMOs, as well as the services that the projects provide to HMOs, may vary greatly.

In pursuing contracts with HMOs, Healthy Start projects should keep the HMO's perspective in mind. In addition, projects can use several broad strategies to enhance their attractiveness to HMOs. Projects should incorporate these strategies when developing a managed care product and marketing it to HMOs. One strategy is to demonstrate how the Healthy Start project can help the HMO provide services (e.g., case management services) that the HMO is required to provide under its Medicaid contract. A second is to demonstrate how the project can help the HMO improve its performance on quality measures (e.g., early prenatal care, immunization rates) that are being used by state Medicaid agencies to evaluate the quality of care provided by HMOs. A third is to prove to HMOs that contracting with the Healthy Start project can be cost-effective by providing services that result in lower medical costs. A final strategy is to generate revenue for the HMO by providing a new revenue source or increasing enrollment.

Because most of the Healthy Start projects will be new to providing services for HMOs, it is likely that the HMOs may be interested in beginning with small-scale contracts or demonstration projects. Even if HMOs enter into larger contracts with Healthy Start projects, the HMOs will spend the first term of the contract evaluating the Healthy Start projects' value as a contracting partner. As a result, the work for the projects does not end with obtaining the contract. Healthy Start projects will need to continue marketing their value to HMOs to sustain the partnership and expand the existing relationship.

While Healthy Start sites and other community-based projects may be new at managed care, they are expert at serving the community. Building bridges to HMOs may not be easy; projects need new skills, new knowledge, and even new language.

Yet, this is not the first major shift that programs such as Healthy Start have made to serve their communities and strive toward meeting their goals—nor will it be the last. Changing with the times is part of this work; it is crucial not only for the program's survival, but for the community's survival.

Appendix A: Glossary of Managed Care Terms[*]

Actuarial assumptions: The assumptions that an actuary uses in calculating the expected costs and revenues of the plan. Examples include utilization rates, age and sex of enrollees, and cost for medical services.

Capitation: A set amount of money received or paid out, based on membership rather than on services delivered, and usually expressed in units of per member per month (PMPM). May vary by such factors as age and sex of enrolled members.

Case management (medical): A method of managing the provision of health care to members with high-cost medical conditions. The goal is to coordinate the care to improve continuity and quality of care and to reduce costs. This generally is a dedicated function in the utilization management department. The official definition, according to the Certification of Insurance Rehabilitation Specialists Commission, is as follows: "Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available health resources to promote quality, cost-effective outcomes" and "occurs across a continuum of care, addressing ongoing individual needs" rather than being restricted to a single-practice setting. [Author's note: In this manual we distinguish medical case management from social case management/care coordination. The latter addresses the psychosocial needs of the person and entails the provision of nonmedical facilitative services.]

Closed-panel HMO: A managed care plan that contracts with physicians on an exclusive basis for services and does not allow those physicians to see patients for another managed care organization. Examples include staff and group model HMOs, and even a large private medical group that contracts with an HMO.

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[*] Adapted from *The Managed Care Handbook*, 3rd ed., by Peter Kongstvedt, with permission of Aspen Publishers, 1996.

Coinsurance: A provision in a member's coverage that limits the amount of coverage by the plan to a certain percentage, commonly 80 percent. Any additional costs are paid by the member out of pocket.

Copayment: That portion of a claim or medical expense that a member must pay out of pocket. Usually a fixed amount, such as $5, in many HMOs.

Credentialing: The most common use of the term refers to obtaining and reviewing the documentation of professional providers. Such documentation includes licensure, certifications, insurance, evidence of malpractice insurance, malpractice history, and so forth. Generally includes reviewing information submitted by the provider as well as verification that the information is correct and complete. A much less frequent use of the term applies to closed panels and medical groups and refers to obtaining hospital privileges and other privileges to practice medicine.

Days per thousand: A standard unit of measurement of utilization. Refers to an annualized use of the hospital or other institutional care. It is the number of hospital days that are used in a year for each 1,000 covered lives.

Direct contract model: A managed care health plan that contracts directly with private-practice physicians in the community, rather than through an intermediary such as an IPA or a medical group. A common type of model in open-panel HMOs.

Diagnosis-related groups (DRGs): A statistical system of classifying any inpatient stay into groups for purposes of payment. DRGs may be primary or secondary, and an outlier classification also exists. This is the form of reimbursement that HCFA uses to pay hospitals for Medicare recipients. Also used by a few states for all payers and by some private health plans (usually non-HMO) for contracting purposes.

Fee schedule: May also be referred to as Fee Maximums or as a Fee Allowance Schedule. A listing of the maximum fee that a health plan will pay for a certain service, based on CPT billing codes.

Full-time equivalent (FTE): The equivalent of one full-time employee. For example, two part-time employees are 0.5 FTE each, for a total of 1 FTE.

Gatekeeper: An informal (though widely used) term that refers to a primary care case management model health plan. In this model, except for true emergencies, all care from providers other than the primary care physician must be authorized by the primary care physician before care is rendered. This is a predominant feature of almost all HMOs.

Group model HMO: An HMO that contracts with a medical group for the provision of health care services. The relationship between the HMO and the medical group is generally close, although there are wide variations in the independence of the group from the HMO. A form of closed-panel health plan.

Health Care Financing Administration (HCFA): The federal agency that oversees all aspects of health financing for Medicare and Medicaid, and also oversees the Office of Managed Care.

Healthplan Employer Data Information Set (HEDIS): Developed by NCQA with considerable input from the employer community and the managed care community, HEDIS is an ever-evolving set of data reporting standards. HEDIS is designed to provide some standardization in performance reporting for financial, utilization, membership, and clinical data so that employers and others can compare performance among plans.

Independent practice association (IPA): An organization that has a contract with a managed care plan to deliver services in return for a single capitation rate. The IPA in turn contracts with individual providers to provide the services on either a capitation basis or a fee-for-service basis. The typical IPA encompasses all specialties, but an IPA may be solely for primary care or may be a single specialty. An IPA may also be the physician organization part of a PHO.

Managed health care: A system of health care delivery that tries to manage the cost and quality of, and access to, health care. Common denominators include a panel of contracted providers that is less than the entire universe of available providers, some type of limitations on benefits to subscribers who use noncontracted providers (unless authorized to do so), and some type of authorization system. Managed health care is actually a spectrum of systems, ranging from so-called managed indemnity through PPOs, POS, open-panel HMOs, and closed-panel HMOs.

Member months: The total of all months that each member was covered. For example, if a plan had 10,000 members in January and 12,000 members in February, the total member months for the year to date as of March 1 would be 22,000.

Mixed model: A managed care plan that mixes two or more types of delivery systems. This has traditionally been used to describe an HMO that has both closed- and open-panel delivery systems.

National Committee for Quality Assurance (NCQA): A nonprofit organization that performs quality-oriented accreditation reviews on HMOs and similar types of managed care plans.

Network model HMO: A health plan that contracts with multiple physician groups to deliver health care to members. Generally limited to large single-specialty or multispecialty groups. Distinguished from group model plans that contract with a single medical group, IPAs that contract through an intermediary, and direct contract model plans that contract with individual physicians in the community.

Open-panel HMO: A managed care plan that contracts (either directly or indirectly) with private physicians to deliver care in their own offices. Examples would include a direct contract HMO and an IPA.

Primary care physician (PCP): Generally applies to internists, pediatricians, family physicians, and general practitioners, and occasionally to obstetrician/gynecologists.

Physician hospital organization (PHO): Legal (or perhaps informal) organizations that bond hospitals and their attending medical staff, frequently developed for the purpose of contracting with managed care plans. A PHO may be open to any member of the staff who applies, or it may be closed to staff members who fail to qualify (or who are part of an overrepresented specialty).

Per member per month (PMPM): Specifically applies to a revenue or cost for each enrolled member each month.

Point of service (POS): A plan in which members do not have to choose how to receive services until they need them. The most common use of the term applies to a plan that enrolls each member in both an HMO (or HMO-like) system and an indemnity plan. Occasionally referred to as an HMO swing-out plan, an out-of-plan benefits rider to an HMO, or primary care PPO. These plans provide a difference in benefits (e.g., 100 percent coverage rather than 70 percent) depending on whether the member chooses to use the plan (including its providers and in compliance with the authorization system) or go outside the plan for services. Dual choice refers to an HMO-like plan with an indemnity plan, and triple choice refers to the addition of a PPO to the dual choice. An archaic but still valid definition applies to a simple PPO, in which members receive coverage at a greater level if they use preferred providers (albeit without a gatekeeper system) than if they choose not to do so.

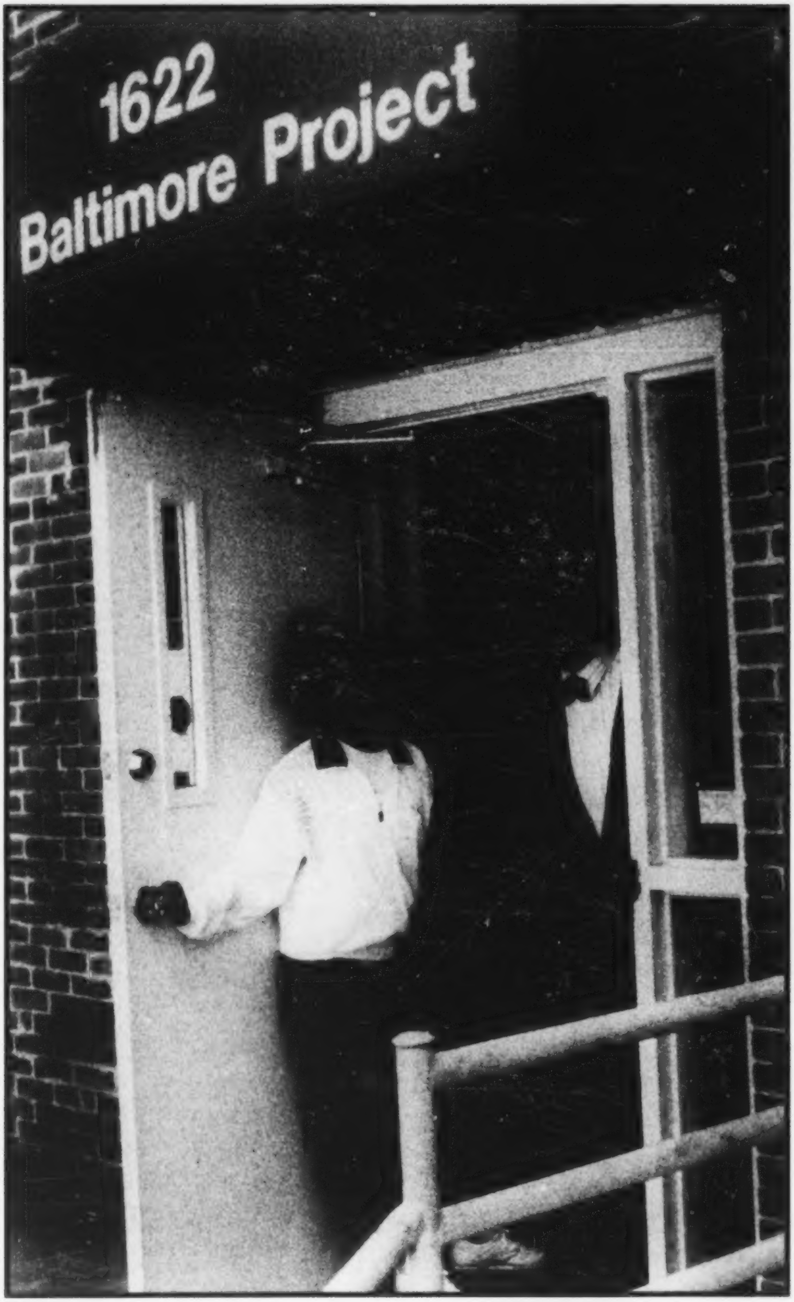
Preferred provider organization (PPO): A plan that contracts with independent providers at a discount for services. The panel is limited in size and usually has some type of utilization review system associated with it. A PPO may be risk bearing, like an insurance company, or may be nonrisk bearing, like a physician-sponsored PPO that markets itself to insurance companies or self-insured companies via an access fee.

Precertification: Also known as preadmission certification, preadmission review, and precert. The process of obtaining certification or authorization from the health plan for routine hospital admissions (inpatient or outpatient), often involving appropriateness review against criteria and assignment of length of stay. Failure to obtain precertification often results in a financial penalty to either the provider or the subscriber.

Staff model HMO: A form of closed-panel HMO, it employs providers directly, and those providers see members in the HMO's own facilities. A different use of this term is sometimes applied to vertically integrated health care delivery systems that employ physicians but in which the system is not licensed as an HMO.

Stop loss: A form of reinsurance that provides protection for medical expenses above a certain limit, generally on a year-by-year basis. This may apply to an entire health plan or to any single component. For example, the health plan may have stop-loss reinsurance for cases that exceed $100,000. After a case hits $100,000, the plan receives 80 percent of expenses in excess of $100,000 back from the reinsurance company for the rest of the year. Another example might involve the plan providing a stop loss to participating physicians for referral expenses in excess of $2,500. When a case exceeds that amount in a single year, the plan no longer deducts those costs from the physician's referral pool for the remainder of the year.

Underwriting: One definition refers to bearing the risk for something (i.e., a policy is underwritten by an insurance company). Another definition refers to the analysis of a group in order to determine rates or to determine whether the group should be offered coverage at all. A related definition refers to health screening of each individual applicant for insurance, and refusal to provide coverage for preexisting conditions.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Baltimore Project

BALTIMORE HEALTHY START

Appendix B. Annotated HMO-Healthy Start Project Contract (Detailed Version)

AGREEMENT BETWEEN
________________________(Healthy Start Project)

AND

______________________________ HEALTH MAINTENANCE ORGANIZATION (HMO)

THIS AGREEMENT is made and entered into on the date set forth on the signature page, by and between ________________ ("Healthy Start project"), which is a not-for-profit corporation in the State of ________ and ________________________ ("HMO"), which is organized and operated as a ____________________ [fill in corporate authority] under the laws of the State of ________.

WHEREAS, HMO operates a managed care plan duly authorized under the laws of the State of ________; and

WHEREAS, the Healthy Start project provides or arranges for the provision of prenatal and perinatal services; and

WHEREAS, HMO has as an objective the development and expansion of cost-effective means of delivering quality health services to Members of HMO, particularly through ensuring appropriate utilization of primary and preventive services by high-risk pregnant and parenting Members, and the Healthy Start project concurs in, actively supports, and will contribute to the achievement of this objective; and

WHEREAS, HMO and the Healthy Start project mutually desire to enter into an agreement whereby the Healthy Start project provides or arranges for services, including social support services, to high-risk pregnant and parenting Members and their children.

NOW, THEREFORE, in consideration of the mutual agreements, undertakings, representations, and warranties specified below and other consideration, the parties hereby agree as follows:

The above statements describe who the parties are and what they are trying to accomplish. These statements are called "Recitals" and are relatively unimportant because they do not contain substantive contractual obligations. However, if the HMO has drafted the recitals, the Healthy Start project should review these statements to confirm their accuracy and ensure that the project is not assuming any unintended responsibilities.

1. DEFINITIONS

The definitions section of a contract plays an important role in simplifying the structure and the reader's understanding of a contract. The body of the contract often contains complicated terms that merit amplification and explanation. The use of a definition, although requiring the reader to refer back to an earlier section for a meaning, simplifies greatly the discussion in the body of the agreement. A poorly drafted contract will define unnecessary terms or define terms in a manner that is inconsistent with their use in the body of the agreement. In the event that a Healthy Start project provides health services, this Definitions section has used a number of "health care provider" related terms, such as primary care physician. In most cases these terms will not be relevant to a Healthy Start project that is not providing health services.

1.1 Covered Perinatal Services means those services identified in Exhibits A and B of this Agreement that will be provided to Members of HMO by the Healthy Start project in accordance with the terms of this Agreement.

From an administrative viewpoint, it is easier to have the contract include the services provided in an Exhibit, rather than the body of the contract. If a Healthy Start project is contracting with several HMOs that want different services, it is easier to make changes to the Exhibit on an individual basis rather than to the body of a contract.

1.2 Encounter Form means a record of services provided by the Healthy Start project to Members in a format acceptable to the HMO.

1.3 Health Professionals means doctors of medicine, doctors of osteopathy, dentists, nurses, chiropractors, podiatrists, optometrists, physician assistants, clinical psychologists, social workers, pharmacists, occupational therapists, physical therapists, and other professionals engaged in the delivery of health services who are licensed, practice under an institutional license, and are certified or practice under other authority consistent with the laws of the State of ________.

1.4 Medical Director means a Physician designated by HMO to monitor and review the provision of Covered Services to Members.

1.5 Member means an individual residing in HMO's service area who is eligible for Medicaid and who has enrolled in HMO and such other enrollees of HMO who are designated under this Agreement as Members of HMO for whom Covered Services will be provided.

1.6 Participating Physician means a Physician who, at the time of providing or authorizing services to a Member, has contracted with or on whose behalf a contract has been entered into with HMO to provide professional services to Members.

1.7 Participating Provider means a Physician, hospital, skilled nursing facility, home health agency, or any other duly licensed institution or Health Professional under contract with HMO to provide professional and hospital services to Members.

1.8 Physician means a duly licensed doctor of medicine or osteopathy.

1.9 Primary Care Physician means a Participating Physician who provides primary care services to Members (e.g., general or family practitioner, internist, pediatrician, or such other physician specialty as may be designated by HMO) and is responsible for referrals of Members to Referral Physicians, other Participating Providers, and, if necessary, nonparticipating providers. Each Member shall select or have selected on his or her behalf a Primary Care Physician.

1.10 Program Requirements means the rules and procedures, including Utilization Management and Quality Management procedures, that establish conditions to be followed by Participating Providers with respect to HMO's program. Program Requirements include the requirements set forth in the applicable Provider Manual.

1.11 Referral Physician means a Participating Physician who is responsible for providing certain medical referral physician services upon referral by a Primary Care Physician.

1.12 Referred (Referral) means written or electronic documentation that the HMO or its designated representative authorized Covered Services to be rendered by the Healthy Start project.

1.13 Service Area means those counties in _________ set forth in Attachment E that HMO has been authorized to provide services under a contract between the HMO and the ________ Department of Health.

2. OBLIGATIONS OF THE HEALTHY START PROJECT

2.1 Covered Services. The Healthy Start project shall provide to or arrange for HMO's Members the Covered Services set forth in Attachment A and Attachment B. The Healthy Start project represents that it is legally authorized to provide such services.

> *The above paragraph allows the Healthy Start project to arrange for the services. This language is intended to permit the Healthy Start project to have its subcontracting service providers provide the services.*

2.2 Charges to Members. The Healthy Start project shall accept as payment in full, for services provided, the compensation specified in Attachment C. The Healthy Start project agrees that in no event, including but not limited to nonpayment by HMO, insolvency of HMO, or breach of this Agreement, shall the Healthy Start project or any of the Healthy Start project's subcontractors bill; charge; collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against a Member, an enrollee, or persons (other than HMO) acting on his/her behalf for services provided pursuant to this Agreement. This provision does not prohibit Healthy Start from collecting supplemental charges or copayments of fees for noncovered services or charging persons who are not members for covered services to the extent authorized by law. The Healthy Start project agrees that this provision shall survive the termination of this Agreement for authorized services rendered prior to the termination of this Agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of HMO's Members. The Healthy Start project agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Healthy Start project and the Member or persons acting on their behalf insofar as such contrary agreement relates to liability for payment for services provided under the terms and conditions of this Agreement.

> *The language in the above paragraph conforms to HCFA requirements and is intended to protect the*

HMO's members from liability if the HMO is unable or unwilling to meet its obligations.

2.3 Records and Reports. The Healthy Start project shall maintain records, in a manner mutually agreeable between HMO and the Healthy Start project, documenting the services provided under this Agreement. The Healthy Start project shall prepare summary reports and encounter-specific reports documenting the services that it provides under this Agreement. The Healthy Start project and HMO shall mutually agree on the format and content of these reports and whether the reports are submitted directly to the HMO and/or the appropriate Participating Physician.

The above paragraph provides that the content and form of reports will be mutually agreed upon between the HMO and the Healthy Start project. The purpose for mutual agreement is to prevent the HMO from unilaterally imposing inappropriate reporting requirements on the Healthy Start project. If the Healthy Start project is contracting on behalf of other organizations that will be providing the services, the Healthy Start project will need to ensure that the other organizations will be able to meet these reporting requirements.

2.4 Provision of Services and Professional Requirements.

2.4.1 Scheduling. The Healthy Start project agrees that scheduling of appointments for Members shall be done in a manner that HMO and the Healthy Start project determine is appropriate.

2.4.2 Nondiscrimination. The Healthy Start project agrees not to discriminate in the treatment of patients or in the quality of services delivered to HMO's Members on the basis of race, sex, age, religion, place of residence, health status, or source of payment.

2.4.3 Licensure and Certifications. The Healthy Start project agrees that all health care or other providers employed by or contracting with the Healthy Start project shall maintain in good standing all licenses and other certifications required for professional practice in the State of ________. The Healthy Start project shall ensure that all professional staff are supervised by appropriate personnel. Upon request, the Healthy Start project agrees to submit copies of all licenses, certifications, and any other credentials as required by HMO for verification by HMO. The Healthy Start project shall notify HMO or its designees immediately upon any lapse in good standing of any license or other certifications for professional practice as represented herein.

2.5 Appropriate Manner. The Healthy Start project shall conduct services in accordance with recognized standards for care consistent with the services provided under this Agreement. The Healthy Start project shall ensure that Covered Perinatal Services shall be provided to Members in a courteous and prompt manner and in a fashion that Members are in no way accorded a different level of treatment than any other persons to whom services are provided. The Healthy Start project shall provide, to the extent applicable, such services consistent with the manner required under the state's Medicaid program.

2.6 Insurance. The Healthy Start project shall provide and maintain such policies of general and professional liability (malpractice) and general liability insurance as shall be necessary to insure the Healthy Start project and its employees against any claim or claims for damages arising directly or indirectly in connection with the performance of any service by the Healthy Start project.

2.7 Administration. To the extent applicable, the Healthy Start project agrees to cooperate and participate in such review and service programs as may be established by HMO, including utilization review and quality assurance programs, credentialing, sanctioning, external audit systems, administrative procedures, and grievance procedures. The Healthy Start project agrees that HMO shall have the right to inspect the Healthy Start project's facilities, equipment, and premises used by the Healthy Start project in connection with the provision of Covered Perinatal Services. The Healthy Start project agrees to make available for inspection by federal and/or state agencies all records related to services provided under this Agreement as is required by federal or state law. The Healthy Start project shall also maintain and provide such medical, financial, administrative, and statistical records and information to HMO as may be necessary for compliance with state and federal law, accrediting body requirements (e.g., National Committee for Quality Assurance). For the aforementioned purposes, the Healthy Start project agrees that access to records and data granted hereunder shall survive the termination of this Agreement.

> *The above requirements are fairly standard in HMO requirements. Some of the HMO programs identified have little applicability to Healthy Start services, which is the reason why the paragraph begins "to the extent*

applicable." Giving federal and state agencies access to records is required by law.

2.8 Subcontract. The Healthy Start project shall not subcontract Covered Perinatal Services under this Agreement to another entity unless the Healthy Start project shall have first notified HMO in advance and received HMO's written approval for such a subcontract provided that such approval shall not be unreasonably withheld. HMO consents to the Healthy Start project subcontracting services to the organizations identified in Attachment D, which may be revised by mutual consent of the parties from time to time. The Healthy Start project shall be financially responsible to the other entity for the Covered Perinatal Services, and HMO shall pay the Healthy Start project for such Covered Perinatal Services on the same basis and at the same rates as if the Covered Perinatal Services had been provided by the Healthy Start project.

The above paragraph establishes a procedure for the approval of Healthy Start project subcontractors. The use of an Attachment to identify approved subcontractors should minimize any disagreements between the HMO and the Healthy Start project on the issue.

2.9 Claims Payment. The Healthy Start project shall submit all claims for payment for Covered Perinatal Services rendered to Members within sixty (60) days after the date on which Covered Perinatal Services were furnished. The Healthy Start project shall submit such claims using the claim form or method approved by HMO. HMO shall have the right to verify the validity of the claims in such manner as HMO may prescribe, depending on the method of submission. For case management services for which a fixed fee has been negotiated for a specific period of time, HMO shall pay the Healthy Start project the amount due within 30 days of the date the Healthy Start project has advised HMO in writing that services have commenced.

Payment terms can vary substantially. The Healthy Start project should suggest terms appropriate for the services that it provides and the circumstances.

2.10 Compliance with Laws under the Medicaid Program. The Healthy Start project agrees to comply with all federal and state laws pertaining to the Medicaid program and to retain all medical and Medicaid-related records for a period of five years or such longer period as required by law. The Healthy Start project agrees to safeguard the use and disclosure of information pertaining to current or former Medicaid recipients and comply with all state and federal laws pertaining to confidentiality of patient information. The Healthy Start project agrees to be liable for and indemnify, defend, and hold the ________ Department of Health **[use the name of the state Medicaid agency]** harmless from all claims, suits, judgments, or damages, including court costs and attorney's fees, arising out of the negligence or omissions of the provider in the course of providing services to a Medicaid recipient or a person believed to be a Medicaid recipient.

3. OBLIGATIONS OF HMO

3.1 Administrative Procedures. HMO shall provide to the Healthy Start project all necessary manuals of administrative procedures (including any changes thereto) relevant to the provision of services covered by this Agreement. The Healthy Start project and HMO will jointly develop administrative procedures manuals applying to the specific services provided for in this Agreement.

> *The Healthy Start project should take the lead in developing procedural manuals for its services.*

3.2 Compensation. For all services provided by the Healthy Start project, HMO shall pay to the Healthy Start project the compensation set forth in Attachment C. For all services provided by the Healthy Start project, HMO agrees to make payment within 30 days of the submission of a claim. For case management services that continue over a period of time, the Healthy Start project may submit a claim on the date services commence. In the event that a claim is incomplete or requires additional documentation, HMO will make payment within 30 days from date of receipt of the completed claim. Payments to the Healthy Start project are subject to retroactive adjustment by HMO or at the request of the Healthy Start project for up to six months following payment. Retroactive adjustments may occur under any circumstance in which payment or the payment amount was in error. Notwithstanding, if the Healthy Start project provides services to an individual who was not an eligible Member of HMO at the time services were provided, HMO shall be responsible for payment up to the date that it notifies the Healthy Start project of the loss of eligibility. If HMO notifies the Healthy Start project of a loss of eligibility during a period in which case management services are being provided, HMO shall continue to be responsible for payment if the authorization for such services preceded such notification of loss of eligibility.

> *The above paragraph accomplishes several objectives. It requires the HMO to pay within a specified period of being invoiced. Service providers occasionally seek interest if the HMO does not pay in a timely manner. HMOs are very reluctant to accept interest payment obligations from late payment. Occasionally, errors are made in payment and this paragraph allows an adjustment within six months of the error. The purpose for identifying a six-month period is to prevent the HMO from raising claims arising from inappropriate payment a long time after the event has occurred. The disadvantage of this approach is that it also prevents the Healthy Start project from raising issues of inappropriate payment after six months. The last sentence of the paragraph ensures that the Healthy Start project is still entitled to payment for services rendered to persons who are later determined to be ineligible unless the HMO had previously notified the Healthy Start project that the person was ineligible to receive services.*

3.3 Referral Procedure. HMO will notify the Healthy Start project of referrals of its Members for services specified in Attachment B by following mutually agreed upon procedures.

3.4 Insurance. HMO shall maintain such policies of general and professional liability (malpractice) insurance as shall be necessary to insure HMO and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned, directly or indirectly, in connection with the performance of any service under this agreement.

3.5 Status of HMO. HMO shall notify the Healthy Start project immediately, by mail and facsimile, if it is found to be out of compliance with any applicable licensure or certification law or its contract to serve Medicaid beneficiaries with the ________ Department of Health. HMO shall also notify the Healthy Start project of any information it obtains from the ________ Department of Health that reflects an intention to modify or terminate the Medicaid contract between HMO and the ________ Department of Health.

3.6 Confidentiality. HMO agrees to keep confidential any patient-specific information provided by the Healthy Start project to HMO or to HMO's Participating Providers except to the extent required by applicable law or the contract between HMO and the ________ Department of Health. HMO agrees to indemnify the Healthy Start project from any damages that the Healthy Start project incurs as a result of the unauthorized disclosure of this information.

4. MISCELLANEOUS

4.1 Modification of this Agreement. This Agreement may be amended or modified in writing as mutually agreed upon by the parties.

4.2 Term and Termination. The initial term of this Agreement shall become effective on the "effective date" set forth on the signature page or the date in which the agreement between the HMO and the ________ Department of Health to provide services to Medicaid beneficiaries becomes effective, whichever is later. The Agreement shall remain in effect for one year. This Agreement may be terminated by either party at any time without cause by prior written notice given at least 60 days in advance of the effective date of such termination. Unless terminated, this Agreement shall be renewed for a period of one year. Upon termination, the rights of each party shall terminate, provided, however, that such action shall not release the Healthy Start project or HMO from their obligations with respect to payments accrued to the Healthy Start project prior to termination, or completion of treatment described under paragraph 2, below, whichever is later; and completion of treatment of Members then receiving care until continuation of the Member's care can be arranged by HMO. This Agreement may be terminated by either party for any material breach of this Agreement, but only if 30 days prior written notice specifying the material breach has been given to the breaching party and, at the end of the 30 days, the material breach has not been cured.

4.3 Notice. Any notice required to be given pursuant to the terms and provisions hereof shall be sent by certified mail, return receipt requested, postage prepaid, to HMO or to the Healthy Start project at the respective addresses indicated herein. Notice shall be deemed to be effective when mailed, but notice of change of address shall be effective upon receipt.

4.4 Confidentiality. The Healthy Start project and HMO agree to keep all information regarding provision of services under this Agreement confidential to the extent required by professional practice and law. The Healthy Start project and HMO shall not disclose any proprietary information of the other party or confidential and personal information concerning the medical, personal, or business affairs of Members acquired in the course of providing Covered Perinatal Services. All information pertaining to business conducted by HMO or the Healthy Start project, including but not limited to, the payment rates and amounts paid for Covered Perinatal Services by HMO, shall be considered confidential and proprietary, and unless required by applicable law, shall not be disclosed by either party without the other party's consent, except as otherwise provided in this Agreement. Nothing in the foregoing, however, shall prevent either party from releasing aggregate data regarding type, volume, and utilization of Covered Perinatal Services.

4.5 Other Party Liability. To the extent applicable, HMO and the Healthy Start project shall cooperate in the identification of sources of payment available to Member, such as other health insurance, government programs, liability coverage, motor vehicle coverage or workers' compensation coverage, as applicable, and shall further cooperate in the determination of primary and secondary liability and abide by HMO's coordination of benefits, policies, and procedures including those set forth in the applicable Provider Manual.

4.6 Independent Contractors. The Healthy Start project and HMO are independent legal entitles. Nothing in this Agreement shall be construed or be deemed to create between them any relationship of employer and employee, principal and agent, partnership, joint venture, or any relationship other than that of independent parties.

4.7 Arbitration. Any controversy, dispute, or disagreement arising out of or relating to this Agreement, or the breach thereof, shall be settled by arbitration, which shall be conducted in **[identify city]** in accordance with the National Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The provisions of this Section apply only to HMO and the Healthy Start project and are not binding upon any Members of HMO.

4.8. Interpretation. This Agreement shall be interpreted consistent with the requirements under HMO's contract with the ________ Department of Health and applicable federal and ________ regulations.

4.9 Assignment. Subject to the provisions set forth above, the Healthy Start project shall not assign, delegate, or transfer this Agreement without the prior written consent of HMO. HMO shall not assign, delegate, or transfer this Agreement without the prior written consent of the Healthy Start project.

4.10 Waiver of Breach. The waiver by either party of a breach or violation of any provision of this Agreement shall not be deemed a wavier of any other breach of the same or different provision.

4.11 Severability. In the event any provision of this Agreement is rendered invalid or unenforceable by an Act of Congress or of the state legislature or by any regulation promulgated by officials of the United states or the applicable state agency, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of these Agreement shall remain in full force and effect.

4.12 Use of Name. The Healthy Start project consents to references to its name and address as a provider of Covered Perinatal Services in HMO's marketing and other materials. All other references to the Healthy Start project in any advertising or published materials shall require the prior approval of the Healthy Start project. The Healthy Start project shall have the right to designate and make oral or published reference to its status as a provider of Covered Perinatal Services.

IN WITNESS WHEREOF, the foregoing Agreement between **[fill in name of the HMO]** , and **[fill in name of the Healthy Start project]** is entered into by and between the undersigned parties, to be effective the _____ day of ____________________, 19___.

MANAGED CARE ORGANIZATION	HEALTHY START PROJECT
By: ______________________________	By: ________________________

Contract Attachment A
Covered Perinatal Services
Social Case Management and Education Services

The discussion of social case management and education services in this section is intended merely to be an example. Healthy Start projects that provide case management services need to develop their own language based on the services they will provide, any locally accepted perinatal protocols, and the financial arrangements negotiated with the HMO.

The following Social Case Management and Education Services shall be provided for under this Agreement:

1. **Universal Screening and Assessment of HMO's Members of Childbearing Age.** The Healthy Start project will provide universal screening and assessment of all new and existing HMO Members of childbearing age (between the ages of 14 and 44). Such screening and assessment shall involve the assessment of referred Members' health, behavioral, and environmental risk factors. The Healthy Start project shall provide the HMO with a detailed statement of the conduct that constitutes an assessment.

As part of the universal screening and assessment, the Healthy Start project will categorize Members in need of social case management services as follows:

Category 1: Very High Risk

Eligible Persons:

Pregnant women

- *Pregnant teen
- *Hx of LBW/infant death
- *Domestic violence
- *Alcohol/substance abuse
- *Positive drug toxicology
- *HIV seropositivity
- *Homelessness
- *Hx of abuse/neglect (child)

Children: < age 3

- *Prematurity or LBW
- *Failure to thrive
- *Developmental delay
- *Hx of abuse/neglect
- *Drug exposure
- *HIV seropositive
- *Major congenital disability

Category 2: High Risk

Eligible Persons:

Women: Pregnant and Postpartum

*Late/no prenatal care
*Parenting teen
*No primary care/episodic care
*Inadequate/unsafe housing
*Psychological history
*Request for postpartum support services
*Medical complications of pregnancy or postpartum period

Children: < age 3

*No well-child care
*No/inadequate immunization
*Domestic violence
*Special needs

Category 3: Moderate Risk

Eligible Persons:

Women of childbearing age (age 14–44)

*Family planning need
*Less than high school education
*Inadequate/unsafe housing
*Positive hepatitis or STD

As part of the universal screen and assessment, the Healthy Start project shall provide basic educational information to Member about how to access health care services, and the benefits and limitations of the HMO's program.

2. **The Healthy Start Project Social Case Management Services for HMO Members.** The level of case management services that the Healthy Start project will provide varies depending on the risk category in which the Member falls. The services that will be provided for each of the three risk categories are as follows:

Category 1: Very High Risk

All very-high-risk pregnant women and children under three years of age shall receive a minimum of 16 units (four hours) of case management service per month which will include:

* At least one home visit per week during prenatal period one month prior to delivery through one month postpartum
* Postpartum home MCH nursing assessment including lactation counseling

- Newborn home evaluation to assess environment and prepare for infant's arrival
- Postpartum case management follow-up to assist parents with adjusting to newborn and to assess child care needs
- Tracking and reporting

Category 2: High Risk

All high-risk pregnant women and children under three years of age will receive a minimum of service units (two hours) per month which will include:

- Prenatal and postpartum home assessment visits by MCH nurse or social worker and case manager
- Assistance and advocacy—Primary care services coordination
- Social resources coordination
- Referrals and basic core services
- Tracking and reporting

Category 3: Moderate Risk

All moderate-risk pregnant women and children under three years of age with demonstrated need will receive services which will include:

- Basic core services (tracking and continued preassessment to determine additional needs), or
- Specific itinerant services to avert a crisis or further deterioration of health or social status

For each HMO Member for whom the Healthy Start project provides case management services, the Healthy Start project shall develop a written service plan; implement the service plan (monitoring of the service plan progress and any needed adjustments to the plan and providing any needed crisis intervention for the Member); and at the conclusion of the period provide whatever services are necessary to close the case.

During the provision of these services, the Healthy Start project shall provide to HMO and to Member's Primary Care Physician or such other physician designated by HMO such information about the services.

The Healthy Start project shall provide the above services for a six-month period. Prior to the end of that period, the Healthy Start project will conduct another screen and assessment and provide HMO with its findings and recommendations. If the Healthy Start project recommends further case management services, the Healthy Start project will not commence those new services without the approval of HMO.

3. **Re-engagement services**. Upon referral by the HMO or an authorized HMO Participating Provider, the Healthy Start project will initiate re-engagement efforts for identified clients who have been lost to care. Re-engagement efforts provided by the Healthy Start project will involve mail, telephone, face-to-face, and other activities. Upon finding the Member, the Healthy Start project shall conduct a screen and an assessment of the Member in the same manner as if the screen and assessment were conducted as part of the universal screen and assessment.

4. **Engagement Services.** Upon referral by the HMO or an authorized HMO Participating Provider, the Healthy Start project will initiate engagement efforts for Members who have not accessed the HMO's health care delivery system and for whom the Healthy Start project was unable to conduct an initial screen and assessment under this Agreement. Upon finding the Member, the Healthy Start project shall conduct a screen and an assessment of the Member in the same manner as if the screen and assessment were conducted as part of the universal screen and assessment.

5. **Member Education Services**. Member education provided by the Healthy Start project will include but will not be limited to ensuring that women and families appropriately use care; educating diverse, multicultural communities; and finding, engaging, and, when necessary, re-engaging enrollees. These services are more extensive than the overview provided to Member during the universal screening and assessment.

Contract Attachment B
Other Covered Perinatal Services

1. **Provider Education Services.** Provider education provided by the Healthy Start project will involve provision or coordination of needed training and education for HMO's Member providers in areas including but not limited to sensitivity to cultural and language differences that inhibit effective delivery of care; social needs of enrollees; barriers to care, such as domestic violence and substance use; and ways to engage and re-engage women and their children in care.

2. **General Community Outreach Services.** General community outreach efforts provided by the Healthy Start project will inform community residents of the benefits of managed care, the mechanisms for using managed care plans, and the environmental and other risk factors that should trigger the utilization of preventive and primary care services when a community resident is enrolled in a managed care plan.

3. **Ombudsman/Conflict Resolution Program.** The Healthy Start project shall perform an ombudsman function to assist in resolving conflicts between a Member and the HMO or its Participating Providers. These services will be further defined by later agreement.

Contract Attachment C

Compensation

[SAMPLE FOR ILLUSTRATIVE PURPOSES—Healthy Start projects will need to adapt or totally revise this structure to meet their particular needs]

1. **Universal Screening and Assessment.** For each screen and assessment, HMO shall pay the Healthy Start project a fee of $ ____. No fee shall be payable if the Healthy Start project is unsuccessful in conducting a screen and an assessment on a Member. The Healthy Start project shall document the screening and services provided and convey the appropriate information to the HMO and the Member's Participating Physician in a manner mutually agreeable between the HMO and the Healthy Start project. HMO and the Healthy Start project acknowledge that a key assumption underlying the amounts negotiated for this service is that the HMO will be referring all Members of childbearing age to the Healthy Start project for screening and assessment.

2. **Social Case Management Services.** The following amounts will be paid by HMO to the Healthy Start project for the provision of social case management services for a six-month period:

Category 1: Very High Risk ....$____________

Category 2: High Risk ....$____________

Category 3: Moderate Risk...........................$____________

3. **Re-engagement Services.**

For finding a Member who has been lost to care and conducting a screen and assessment, HMO shall pay the Healthy Start project $_______ per Member. If the Healthy Start project is unsuccessful in locating the Member and conducting the screen and assessment, HMO shall compensate the Healthy Start project $_________ per Member for its services.

4. **Engagement Services.** For finding a Member who is a new enrollee of HMO, but whom HMO cannot locate, and conducting a screen and assessment, HMO shall pay the Healthy Start project $_______ per Member. If the Healthy Start project is unsuccessful in locating the Member and conducting the screen and assessment, HMO shall compensate the Healthy Start project $_________ per member for its services.

5. **Educational Services.** The following compensation shall apply for the provision of educational services:

Member Education Services................ $ ______ per unit of service
(e.g., a class or series of classes)
Provider Education Services............... $ ______ per unit of service

6. **Other Services.**

General Community Outreach............. $ ______ per unit of service
Ombudsman/conflict Resolution.......... $ ______ per unit of service

Contract Attachment D

APPROVED SUBCONTRACTORS

Appendix C. Annotated HMO-Healthy Start Project Contract (Short Version) [Letter Agreement Between Healthy Start Project and HMO]

__________, 199_

____
____
____
____

Re: Letter Agreement

Dear __________:

This Letter Agreement ("Agreement") outlines the terms under which Metropolis Healthy Start project (Healthy Start project) will provide services to __________ ("HMO"). This Agreement shall commence on __________ and continue until __________. The following terms and conditions shall apply to this Agreement:

1. The Healthy Start project shall provide the following services to HMO:

> *The project needs to insert the services (e.g., social case management, outreach, education, counseling) to be provided. The project needs to be comfortable with the level of specificity of these tasks. If the Healthy Start project believes that a fairly extensive discussion of services is appropriate, that discussion could be included in an attached Exhibit.*

2. HMO shall make payments to the Healthy Start project in the following amounts and manner:

Insert payment amount, whether the Healthy Start project needs to bill, and when HMO must make payment.

3. Each party agrees to comply with all applicable federal and state laws, including confidentiality laws, record-keeping requirements, Medicaid requirements, and applicable certification and licensure requirements.

4. All information or data relating to the business or operations of each party to this Agreement acquired by any other party shall be treated as confidential by the acquiring party.

5. The Healthy Start project agrees to cooperate with HMO's procedures to resolve enrollee complaints and with its case management, utilization review, and quality assurance programs.

6. The parties are hereto and shall remain during the term of this Agreement independent contractors.

7. The Healthy Start project and HMO agree to work cooperatively to develop mutually acceptable operating procedures to carry out the parties' respective responsibilities under this Agreement.

8. The Healthy Start project shall not assign, delegate, or transfer this Agreement without the HMO's prior written consent, which shall not be unreasonably withheld.

9. The Healthy Start project agrees to be liable for and indemnify, defend, and hold the ________ Department of Health/Human Resources *[use the name of the state Medicaid agency]* harmless from all claims, suits, judgments, or damages, including court costs and attorney's fees, arising out of the negligence or omissions of the Healthy Start project in the course of providing services to a Medicaid client.

10. The Healthy Start project shall accept as payment in full, for services provided, the compensation specified above. The Healthy Start project agrees that in no event, including but not limited to nonpayment by HMO, insolvency of HMO, or breach of this Agreement, shall the Healthy Start project or any of the Healthy Start project's subcontrac-

tors bill; charge; collect a deposit from; seek compensation, remuneration, or reimbursement from; or have any recourse against a Member, an enrollee or persons (other than HMO) acting on his/her behalf for services provided pursuant to this Agreement. The Healthy Start project agrees that this provision shall survive the termination of this Agreement.

11. The Healthy Start project agrees not to discriminate in the treatment of patients or in the quality of services delivered to HMO's Members on the basis of race, sex, age, religion, place of residence, health status, or source of payment.

12. This Agreement contains the entire understanding between the parties and supersedes any and all prior agreements, understandings, and arrangements.

If these terms are acceptable to you, please sign below.

Sincerely,

Metropolis Healthy Start project

By:______________________

AGREED AND ACCEPTED:

By:__________________________

Title:__________________________

Appendix D. Healthy Start Project Subcontractor Agreement

This AGREEMENT is entered into between Metropolis Healthy Start project (Healthy Start project), a ______________ Corporation, and the undersigned (Subcontractor).

1. Preamble. Healthy Start project has entered into an agreement or agreements with health maintenance organizations (HMOs). Under the terms of these agreements, the Healthy Start project has agreed to provide or arrange for the provision of certain services to enrollees of HMOs.

2. Definitions.

(a) "Enrollee" means a Medicaid client entitled to receive health services under an agreement between the state Medicaid agency and HMO and any other persons specifically designated as an Enrollee in the agreement between the HMO and the Healthy Start project for whom the Healthy Start project will provide services.

This language is intended to give the Healthy Start project and the subcontractor the ability to extend coverage to non-Medicaid clients.

(b) "HMO" means a health maintenance organization or such other organization that has entered into an agreement with the state Medicaid agency to provide a comprehensive range of services to Medicaid clients in exchange for a capitation payment.

The Healthy Start project and the subcontractor may want to broaden these definitions to apply outside the Medicaid context.

3. Services.

(a) Subcontractor recognizes the obligation of the Healthy Start project to provide, arrange, and be responsible for certain services under the terms of agreement(s) between the Healthy Start project and HMOs. Subcontractor agrees to provide Enrollees those services which Subcontractor commonly performs and which are specified in Exhibit A, in accordance with the terms of the agreements between the Healthy Start project and HMOs. Subcontractor agrees to render these services to Enrollees in the same manner, in accordance with the same standards, and within the same time availability as offered to other patients of Subcontractor.

(b) Subcontractor agrees to provide services in accordance with the procedures of the Healthy Start project, if any, and the procedures of the applicable HMO, to the extent that the procedures are authorized by the Agreement between Healthy Start project and HMO.

(c) Subcontractor agrees to submit such reports to the HMO and the Healthy Start project as may be required by Healthy Start project and HMO.

4. Participation Conditions. To the extent feasible, Subcontractor will:

(a) Make certain that services will be provided in a manner intended to preserve human dignity;

(b) To the extent permitted by state and federal laws and regulations, participate in the sharing of medical records and other records, equipment, and professional, technical, and administrative staff; and

(c) Participate in those continuing education programs in accordance with guidelines and minimum requirements of HMO and Healthy Start project.

5. Subcontractor's Compensation.

(a) Subcontractor's compensation for health services shall be determined by the payment terms negotiated between Healthy Start project and the HMOs.

> *If the Subcontractor has any limitations on the ability of the Healthy Start project to negotiate on its behalf or if the Subcontractor wants a right to be consulted prior to entering into an agreement, those provisions should be stated here. If the payment terms between the Healthy Start project and the subcontractor are not specified in the Healthy Start project-HMO agreement, this paragraph will need to identify the amount of the compensation or how it will be determined.*

(b) Subcontractor agrees to seek compensation for covered services solely from the HMO or Healthy Start project, as appropriate, and not, under any circumstances, from the Enrollees, except for approved deductibles, coinsurance, and copayments. As long as Subcontractor bills for health services directly to HMO or its representative, Subcontractor shall submit claims in the manner specified in the applicable agreement between Healthy Start project and the HMO.

6. Consent to Healthy Start Project Policies and Terms of Healthy Start Project-HMO Agreements. Subcontractor agrees to abide by and cooperate with the guidelines, policies, and procedures of the Healthy Start project. Subcontractor further agrees to abide by the applicable terms of the agreements between Healthy Start project and HMOs, including any guidelines, policies, and procedures that are incorporated by reference into those agreements. These responsibilities include, but are not limited to, cooperation with the Healthy Start project and the HMO's credentialing program, quality assurance program, and utilization review program, and shall include such changes that are made from time to time. Copies of the Healthy Start project-HMO agreements and Healthy Start project policies and procedures shall be provided to and be made available to Subcontractor.

7. Credentialing. Subcontractor agrees that any health professional employed by or contracting with Subcontractor shall meet all applicable licensure requirements and meet any applicable credentialing requirements of the HMOs.

8. Insurance. Subcontractor agrees to maintain such policies of liability insurance as are necessary to insure Subcontractor and its employees against claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Subcontractor provided under this Agreement. To the extent the agreements between Healthy Start project and HMOs establish minimum liability coverage limits applicable to Subcontractor, Subcontractor agrees to meet such limits. Upon request of an HMO or the Healthy Start project, Subcontractor agrees to provide documentary evidence of such insurance policy or policies.

> *It may be possible for the Healthy Start project to assume the responsibility for obtaining and paying for the liability coverage.*

9. Records. Subcontractor agrees to keep such medical, administrative, and financial records, and furnish such information to the Healthy Start project or the HMOs as may be reasonably required by the Healthy Start project or the HMOs in carrying out their responsibility under this Agreement or the agreements between the Healthy Start project and HMOs. Subcontractor shall make such records available for inspection by the Healthy Start project or HMOs during normal business hours, provided, however, that Subcontractor shall have no obligation to disclose conditional information without proper authorization. Subcontractor agrees to comply with all state and federal laws, including laws under the Medicaid program, regarding the confidentiality of patient records, record keeping, and access to records and other information for auditing purposes.

10. Enrollee Grievances. Subcontractor agrees to cooperate with HMOs in the implementation of their grievance procedures and to assist HMOs in taking appropriate corrective action.

11. Assessments. Subcontractor agrees to pay a periodic assessment to Healthy Start project in the following amount and manner:

> *This paragraph needs to specify how the Healthy Start project will fund its operations. One option is to allow the Healthy Start project to retain a certain percentage of the revenue from the services that the Subcontractor provides. If so, this issue would need to be addressed in Paragraph 5(a) above.*

12. Healthy Start Project Responsibilities. Consistent with the procedure set forth in Section 5(b) above, the Healthy Start project agrees to negotiate and contract with HMOs for the provision of health services furnished by Subcontractor. Further, if directed by the Subcontractors, the Healthy Start project agrees to perform such additional services necessary to coordinate its services to Enrollees.

13. Term and Termination.

(a) Term. This Agreement shall be effective as of the date both parties execute this Agreement and shall remain in effect for a period of one year. Thereafter, this Agreement shall automatically renew for successive one-year periods.

The Healthy Start project may consider coinciding the terms of this Agreement with the agreement between the Healthy Start project and the HMO(s).

(b) Termination Without Cause. This agreement may be terminated by either party by written notice given at least one hundred twenty (120) days in advance of such termination. Upon such termination, the rights of each party hereunder shall terminate, provided, however, that such action shall not release Subcontractor from its obligation not to seek compensation from Enrollees and such other obligations that are imposed on Subcontractor by the agreements between the Healthy Start project and HMOs.

(c) Termination for Cause. Except as provided in paragraph (2) below, if either party defaults in its responsibilities under this Agreement, the party claiming default may terminate this Agreement by:

(1) Giving the other party written notice of default;
(2) Allowing the other party 30 days from receipt of notice to remedy the default; and
(3) If the default is not remedied within this period, giving the other party at least 30 days final written notice of termination.

14. Miscellaneous.

(a) Waiver. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof.

(b) Governing Law. This Agreement shall be governed in all respects by the Laws of ________.

(c) Severability. The invalidity or unenforceability of any terms or conditions hereof shall in no way affect the validity or enforceability of any other terms or provisions.

(d) Assignment. Neither party to this Agreement shall assign or otherwise transfer this Agreement or any interest in this Agreement without the written consent of the other party.

(e) Independent Parties. In the performance of this Agreement and in rendering medical services as provided herein, Subcontractor shall at all times act as an independent contractor.

(f) Authorized Use of Information. Subcontractor agrees that the HMOs may use its name, address, telephone number, and type of practice in its roster of participating providers and other HMO material and may use such other information authorized by the agreement between Healthy Start project and HMO.

(g) Nonexclusivity. This Agreement does not limit the ability of Subcontractor to contract with other parties, including parties with whom Healthy Start project may negotiate or contract, for the provision of health services.

15. Amendment. This Agreement may be amended by the mutual written consent of Healthy Start project and Subcontractor.

16. Notice. Any notice required to be given pursuant to this Agreement shall be sent by mail, fax, or hand delivery, to Healthy Start project at:

____

____

____

and to Subcontractor at:

____

____

____

IN WITNESS WHEREOF, the undersigned have executed this Agreement.

Healthy Start project

Date: ________________ By: ______________________________
Director

Subcontractor (insert name of Subcontractor)

Date: ________________ By: ______________________________

____
Title

Appendix E. State Medicaid Directors

Alabama

Gwendolyn Williams
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, AL 36103-5624
Phone: (334) 242-5600
Fax: (334) 242-5097

Alaska

Bob Labbe
Director
Alaska Department of Health and Social Services
P.O. Box 110660
Juneau, AK 99811-0660
Phone: (907) 465-3355
Fax: (907) 465-2204

Arizona

Jack Kelly
Director
Arizona Health Care Cost Containment System (AHCCCS)
701 East Jefferson, P.O. Box 25520
Phoenix, AZ 85002-5520
Phone: (602) 417-4680
Fax: (602) 252-6536

Arkansas

Ray Hanley
Director
Department of Human Services
P.O. Box 1437, Slot 1100
Little Rock, AR 72203
Phone: (501) 682-8292
Fax: (501) 682-8013

California

Doug Porter
Acting Deputy Director
California Department of Health Services
714 P Street
Sacramento, CA 95814
Phone: (916) 654-0391
Fax: (916) 657-1156

Colorado

Richard Allen
Medicaid Director
Health and Medical Services
1575 Sherman
Denver, CO 80203-1714
Phone: (303) 866-2859
Fax: (303) 866-2803

Commonwealth of the Northern Mariana Islands

Maria A.V. Leon Guerrero
Medical Administrator
Department of Public Health and Environmental Services
Commonwealth of the Northern Mariana Islands
Saipan, CM 96950
Phone: 670-234-8950, ext. 2905

Commonwealth of Puerto Rico

Margarita Latorre
Medicaid Director
Office of Economic Assistance to the Medically Indigent
Department of Health
San Juan, PR 00936
Phone: (809) 765-1230
Fax: (809) 250-0990

Connecticut

David Parrella
Deputy Director
Connecticut Department of Social Services
25 Sigourney Street
Hartford, CT 06106
Phone: (860) 424-5116
Fax: (860) 424-4958

Delaware

Phillip P. Soule
Deputy Director
Department of Health and Social Services
P.O. Box 906, Lewis Building
New Castle, DE 19720
Phone: (302) 577-4901
Fax: (302) 577-4405

District of Columbia

Paul Offner
Commissioner
Department of Human Services
2100 Martin Luther King, Jr. Avenue
Washington, DC 20020
Phone: (202) 727-0735
Fax: (202) 610-3209

Florida

Gary Crayton
Director of Medicaid
Agency for Health Care Administration
P.O. Box 13000
Tallahassee, FL 32317-3000
Phone: (904) 488-3560
Fax: (904) 488-2520

Georgia

Marge Smith
Commissioner
Georgia Department of Medical Assistance
2 Peachtree Street
Atlanta, GA 30303-3159
Phone: (404) 656-4507
Fax: (404) 657-5238

Guam

Adoracion Solidum
Administrator
Department of Public Health and Social Services
P.O. Box 2816
Agana, GU 96910
Phone: (671) 734-7269
Fax: (671) 734-5910

Hawaii

Reuben Shimazu
Assistant Administrator
Department of Social Services
820 Mililani Street
Honolulu, HI 96813-2938
Phone: (808) 586-5392
Fax: (808) 586-5389

Idaho

Tresa Newman
Administrator
Department of Health and Welfare
450 West State Street
Boise, ID 83720
Phone: (208) 334-5747
Fax: (208) 332-7342

Illinois

A. George Hovanec
Administrator
Illinois Department of Public Aid
201 South Grand Avenue East
Springfield, IL 62763-0001
Phone: (217) 782-2570
Fax: (217) 782-5672

Indiana

Kathleen D. Gifford
Assistant Secretary
Indiana Family and Social Services Administration
402 W. Washington Street
Indianapolis, IN 46204-2739
Phone: (317) 233-4455
Fax: (317) 232-7382

Iowa

Donald W. Herman
Administrator
Iowa Department of Human Services
Hoover State Office Building
Des Moines, IA 50319-0114
Phone: (515) 281-8794
Fax: (515) 281-7791

Kansas

Anne E. Koci
Commissioner
Department of Social and Rehabilitation Services
915 S.W. Harrison, Room 628-S
Topeka, KS 66612
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Fax: (913) 296-4813

Kentucky

John H. Morse
Commissioner & Secretary for Health Services
Department for Medicaid Services
275 Easy Main Street
Frankfort, KY 40621
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Fax: (502) 564-3866

Louisiana

Thomas D. Collins
Director
Louisiana Department of Health and Hospitals
1201 Capitol Access Road
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Fax: (504) 342-9508

Maine

Francis T. Finigan, Jr.
Director
Department of Human Services
State House Station #11
Augusta, ME 04333
Phone: (207) 287-2093
Fax: (207) 287-2675

Maryland

Martin P. Wasserman, M.D., J.D.
Secretary
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201
Phone: (410) 767-6505
Fax: (410) 767-6489

Massachusetts

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MCHB
Maternal and Child Health Bureau

NCEMCH
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